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**THE MANAGEMENT OF TEMPORARY STAFF IN HEALTHCARE EMERGENCY DEPARTMENTS
IMPLICATIONS FOR PATIENT SAFETY AND SERVICE QUALITY**

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Author:Zofia Bajorek

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**THE MANAGEMENT OF TEMPORARY STAFF
IN HEALTHCARE EMERGENCY
DEPARTMENTS:
IMPLICATIONS FOR PATIENT SAFETY AND
SERVICE QUALITY**

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Abstract

The use of temporary staff in healthcare presents a management challenge. There is a case for minimising their use to reduce the risks associated with their limited familiarity with the context and knowledge of protocols. However, staff shortages can negatively affect patient outcomes. Consequently, temporary staff are required but need to be carefully managed. This thesis uses the analytic framework of the psychological contract to explore the previously neglected management of the employment relationship with temporary staff.

The empirical research consisted of two studies. The first explored the management of temporary staff in Emergency Departments (ED), analysing management perspectives at macro, meso and micro levels. The second studied the management of the launch of a Major Trauma Centre introducing a Consultant Resident On-Call for trauma, which required temporary contracts. The research was conducted through case studies utilising semi-structured interviews. The ED was specifically chosen because of its high use of temporary staff, and its particular challenges associated with patient care.

Results indicated a conflict between the priorities of senior management to minimise staff costs, and department level management, concerned with staffing levels to maintain patient care and service delivery. Risks to patient safety, particularly when ad-hoc agency staff were recruited, were identified. Study 2 revealed a shift from relational to transactional psychological contracts when consultants were placed on temporary contracts due to the protracted management of the change process and perceived psychological contract breach. The results highlighted the distinctive characteristics of temporary staffing in healthcare, and the hierarchy of preferences

between the types of temporary staff identified. The research also revealed the consequences of the competing priorities between different management levels in the hospital. Finally, the studies revealed that the psychological contracts of temporary staff were predominantly transactional, whereas a more relational contract could improve temporary staff use and patient outcomes.

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Chapter 1: Introduction

1.1 The Broad Context

This thesis is concerned with the management of temporary staff in healthcare and the implications for patient safety and service quality. As patient safety has become of international importance, this thesis will also explore ways to reduce any potential risks when using temporary staff and aims to develop a model of best practice when employing temporary staff to ensure optimal use for positive patient safety and service quality.

Temporary employees are used extensively in healthcare, and remain a key component of a hospital's ability to meet fluctuations in demand, to cover vacancies or short-term staff absences, and to ensure requisite staffing levels for the provision of safe and effective patient care (National Audit Office, 2006). Expenditure on temporary staff is usually provided as evidence of high temporary staff use (Hurst and Smith, 2011), as the Department of Health does not have exact figures on the number of temporary staff working in the National Health Service (NHS) (House of Commons Committee of Public Accounts, 2007).

The Department of Health (2002) recognised that greater consistency in the co-ordination and use of temporary staff in healthcare was necessary, not solely for ensuring value for money, but for improving the level of patient care that temporary staff offer. Evidence suggests using temporary staff could negatively affect patient safety and service quality. For example, the National Audit Office (2006) reported a triangular relationship between the use of temporary staff, patient satisfaction scores and hospital staff vacancies – when vacancies increased, this was matched with an

increased tendency to use temporary staff and reduced patient experience. Ball and Pike (2006) described the use of temporary employees as problematic for quality and continuity of patient care, while Aiken, Xue, Clarke and Sloane (2007) cited concerns relating to less familiarity with the local hospital environment, limited knowledge of specific hospital processes and procedures and disruptions to team communication. In healthcare environments where there is a need for co-ordinated patient care, and especially in Emergency Departments where rapid decisions and effective communication are vital, alongside the government restrictions to patient waiting times, minimising staff-related risks to patients requires effective management.

There is a growing body of literature discussing the use of temporary staff and its impact on organizational and individual outcomes (e.g. De Cuyper, De Jong, De Witte, Isaksson, Rigotti and Schalk, 2008; De Witte and Näswell, 2003; Gallagher and Sverke, 2005). This highlights a perception that temporary employees are disadvantaged in terms of the induction, training and opportunities for personal development they receive and suggests they may experience reduced job satisfaction (Jordan, 2003; Wheeler and Buckley, 2000). Allied to this is a concern that performance may be negatively affected if temporary staff do not have the necessary information and training, or do not feel sufficiently committed to the organization to undertake the roles they have been hired to fill. One way of exploring the relationship between employees and the organization is through the concept of the psychological contract (Rousseau, 1989, 1990; Guest and Conway, 2002), the perceptions of both the organization and the employee regarding the reciprocal obligations implied in the employment relationship (Guest, Isaksson, De Witte, 2010). This will be explored in greater detail in Chapter 2.

Given the extensive use of temporary staff and the distinctive challenges of the work, the employment and management of temporary staff in healthcare presents a major management challenge. Logic would suggest minimising the use of temporary staff if there are risks related to familiarity with protocols and systems, concerns regarding training and potential risks to the quality of care they provide. However, simultaneously, a body of literature suggests that staffing vacancies and inadequate staff to patient ratios may also negatively affect patient outcomes (Newman, Maylor and Chansarkar, 2001). Recent research conducted in 12 European countries and the United States (Aiken, Sermeus, Van den Heede, Sloane, Busse et al., 2012), aimed to determine whether hospitals with good organization of care (such as improved staffing and working environments) can affect patient care. Results indicated that hospitals with good working environments (managerial support, organizational priorities on care quality etc) and nurse staffing (patient to staff ratios) had improved outcomes for both patient satisfaction rating and nurse outcomes (job satisfaction, burnout and intention to quit). Additionally, there were increased odds of nurses reporting poor or fair quality of care for every extra patient per nurse. Patients in hospitals with higher ratios of patients to nurses (therefore, increased nurse workload) were less likely to rate the hospital highly. Results from the study also suggested that associations between nursing and the quality and safety of hospital care were similar across Europe and the United States.

If there are risks both in using temporary staff and not using them, the way in which managers resolve this dilemma and in particular the way they seek to minimise risk when using temporary staff offers an interesting area of research. Questions are then raised concerning why temporary staff are needed in healthcare, what employment and management strategies are applied to minimise any risks to patient safety and

service quality associated with their use, and how effective these management strategies are, particularly in especially challenging contexts, such as Emergency Departments. The broad aim of this thesis is to explore these questions.

1.2 Temporary Employment: A Brief Introduction

There is evidence to suggest that various forms of employment flexibility, of which contract flexibility is just one example, have become increasingly applied in industry in recent years (Guest, 2003; Guest, 2004a; De Cuyper, De Witte and Van Emmerick, 2011). Temporary employment contracts are not a new form of flexibility, but they have become a focus of increased research as a result of the potential consequences they can have for organizations and individuals (Kalleberg, 2009).

In the United Kingdom (UK) the British Labour Force Survey provides a reliable measure for estimating temporary employment (Forde, Slater and Green, 2008). This is a household survey that has provided a consistent measure of temporary workers since 1992. Guest (2004b) noted the temporary workforce represented approximately 7.8 percent of the working population in 1997, but this had declined to 6.8 percent by 2001. In 2005, 5.5 percent of the working population were employed on temporary contracts (Green, 2008), and temporary employment rates have since remained stable at 5.5-5.6 percent. The proportion of temporary employment use in the UK is low in comparison with many EU countries (Forde and Slater, 2006).

Different categories of temporary employment have been identified in the literature. Forde, et al., (2008) reported that fixed-term contracts are the most common form of

temporary contract in the UK. Other forms of temporary employment include temporary employment agencies (Gray, 2002), independent contractors (Connelly and Gallagher, 2004) and seasonal workers (Casey, 1998). The lack of a standardised definition of temporary employment has often hindered accurate estimates of its occurrence, and can influence the discussion of findings in relation to organizational and individual outcomes. A definition of temporary employment commonly cited is that of the Eurostat:

“A job may be regarded as temporary if it is understood by both employer and employee that the termination of the job is determined by objective conditions such as reaching a certain date, completion of an assignment or return of another employee who has temporarily been replaced” (Eurostat, 1996, p. 45)

A shorter, similar definition, developed by the OECD in 2002, described temporary employment as *“dependent employment of limited duration”* (De Cuyper, Mauno, Kinnunen, De Witte, Mäkikangas and Nätti, 2010, p 40). This definition will be used throughout this thesis. The definition notes the transitory and temporarily unstable nature of this form of employment. However, the definition does not reflect the heterogeneity of temporary contracts briefly described above, and the distinction between different forms of temporary employment will be important in this research, as it is a distinctive feature of temporary employment in healthcare.

1.3 Temporary Employment in Healthcare: A Brief Introduction

In the last decade, reports have suggested extensive use of temporary staff in healthcare. The Department of Health (2002) described an increasing trend of

temporary staff use in UK hospitals to fill vacancies as hospitals failed to recruit sufficient numbers of permanent staff. Although, in recent years the NHS's expenditure for temporary staff (particularly temporary agency staff) has reduced (aided by the development of internal staff banks – an alternative, yet cheaper form of temporary staff) (de Ruyter, Kirkpatrick, Hoque, Lonsdale and Malan, 2008), temporary staffing costs are still a disproportionate amount of hospital expenditure (Hurst and Smith, 2011).

Over the last decade, the increased use of temporary staff (especially agency nursing staff) in the NHS (de Ruyter, 2007) has become a controversial issue. The House of Commons Committee of Public Accounts (2007) reported that 9 percent (although there may be regional fluctuations) of the expenditure for nurses in the NHS was used for the employment of temporary nurses, even though attempts had been made to increase the nursing workforce to reduce the need for temporary employment. The same report also noted there were no exact figures regarding the number of temporary staff currently being used in the NHS, as the different types of temporary nursing staff made the situation difficult to monitor. This is a result of the range of temporary staff employed, including bank and agency staff (which could include those who work exclusively for either the bank or agency, and those who work permanently in a hospital and take on extra shifts) as well as locums. In addition, as The House of Commons Committee of Public Account (2007) argues, hospitals have not adopted strategic approaches to managing and monitoring temporary staff use. Furthermore, it has been difficult to assess recent trends in temporary nursing staff use because of a paucity of published data (Mercer, Buchan and Chubb, 2010). The National Audit Office (2006) stated that high levels of unmanaged temporary staff

can be financially costly, especially when the NHS places a heavy level of reliance on temporary staff.

Much of the literature on temporary staff in healthcare is focussed on nursing – which is understandable as nurses make up a large proportion of the hospital workforce - but it is important to emphasise that temporary employment in the NHS extends beyond the nursing workforce. Other categories of healthcare staff are also employed as temporary employees (locums, allied health professionals), as well as staff based in clerical and administrative positions.

The National Audit Office's (2006) document, "Improving the use of temporary nursing staff in NHS acute and foundation trusts", noted that discussions regarding temporary staff had primarily revolved around reducing the costs of agency staff, with less attention being paid to wider issues such as controlling and managing the supply of and demands for temporary staff, and the difference in service quality and patient care provided by different forms of temporary contracts. It was also noted that hospitals have no way of benchmarking the performance of temporary nursing staff in any meaningful way. The House of Commons Committee of Public Account report (2007) concluded that hospitals should develop local strategies to improve their understanding and management of demand for temporary staff (nurses in particular) underpinned with the requisite notion of providing safe care. The report also added that hospitals should attempt to obtain temporary staff at best value for money, underpinned by quality measures, with guidance to wards as to the preferred routes for booking temporary staff. However, with the report from the Royal College of Surgeons (2010) indicating that locum spend had risen to more than £750 million, it appears that managerial planning for temporary staff use is still a

challenging issue in the NHS. Thus, research into the management of temporary staffing and the impact on patient safety and service quality is timely.

Hoyal (1998) had argued there was a failure in the literature to research temporary medical locums, including their assessment, evaluation and standards, with very little research on the quality of temporary locum care provided. Alonzo and Simon (2008) acknowledged the limited understanding about what roles medical locums undertake, but more importantly, there was little literature concerning their commitment to and satisfaction in the role. Audit Scotland (2010) released a report based on locum use in the NHS in Scotland, indicating that the amount spent on locums has increased, mostly resulting from the increase of agency locum use. They concluded that money would be saved if the workforce was planned and managed more strategically, and that reducing the level of temporary locum use could potentially reduce clinical risk. However, the report did not explore how they are managed, and how this could influence the service they provide.

Richardson and Allen (2001) described how the use of temporary nurses is international, and that their use is unlikely to be reversed in the near future as a result of changing employment laws, increased worker flexibility and economic fluctuations resulting in workforce constraints. It was argued that their efficacy should be debated, as the need to ensure a safe, efficient and effective service continues to be on national Government agendas, as highlighted in the Operating Framework for the NHS in England for 2010/2011 (Department of Health, 2009). Peerson, Aitken, Manias, Parker and Wong (2002) argued that temporary agency nursing in Australia was a poorly understood and under-researched phenomenon. They noted that much of the evidence surrounding temporary hospital staff has been anecdotal, and largely consists of first person accounts, opinions and perceptions

regarding temporary staff. They added that although there are calls for tighter controls over the use, supply and quality of temporary agency staff in hospitals, there have been relatively few empirical studies addressing the management of temporary staff and their impact on patient safety and service provision. This concern has been echoed by a number of other authors including de Ruyter (2004), Page (2008), Hass, Coyer and Theobald, (2006) and Creegan, Duffield and Forrester, (2003). Hoque, Kirkpatrick, De Ruyter and Lonsdale (2008) studied the impact of contractual relationships of NHS agency staff, with regards to the development of framework agreements between hospital employers and agency services when recruiting temporary employees. Although the introduction of contractual agreements with specific agencies served to reduce the direct financial costs of temporary staff in the short-term, there were indirect impacts upon the way relationships are formed and how temporary staff are matched to positions – which could have an impact on patient safety and service quality. The management of temporary staff in the NHS still remains a prominent topic for consideration, especially when patient outcomes are potentially affected.

In summary, many observers have noted with concern, a lack of information about the numbers, types and use of temporary staff in healthcare and the absence of research about their management and impact on patient safety and service quality. These concerns have invariably been linked to a call for better research to remedy this deficit. A core aim of this thesis is to research the management and employment of temporary staff in healthcare, focussing on the potential risks to patient safety and service quality and to identify ways in which the risks can be minimised.

1.4 The Management of Temporary Employees: A Brief Introduction

Literature discussing the use of temporary staff in organizations is beginning to focus on their management and the changes in the employment relationship this more flexible employment strategy necessitates. Hall (2006) indicated that the management of temporary staff will be an ongoing issue for human resource management, and may provide some challenges to traditional management practices. Commitment is considered to be an important dimension of human resource management, with the underlying assumption that workers who are highly committed would be more productive and that management require employees to be committed to organizational goals (Blyton and Turnball, 1992). Tensions and paradoxes can then become evident in the relationship between human resource management approaches and flexible employment strategies (Bryson and Blackwell, 2006). If an organization is to introduce temporary employment practices how will this level of flexibility match other organizational objectives such as stability, continuity and cohesion? In addition, if temporary employees are only used for a limited period of time, how can employment commitment be secured and sustained to achieve quality output (Blyton and Turnball, 1992)?

These conflicts and contradictions are important to consider when managing temporary employees. As will be discussed in Chapter 2, organizational use of temporary staff could result from a number of strategies designed to provide an organizational competitive advantage. As Blyton and Morris (1992) argued, flexible employment strategies have the potential to reduce the training and development provided to temporary staff and temporary staff may be less likely to achieve consistently high levels of production compared to permanent staff. Stanworth and

Druker (2006) found temporary employees received only very basic training and induction but are expected to step straight into a position. If organizational goals of improved employee commitment, quality output and team integration are to be achieved, then managers must find ways to develop appropriate employment relationships with temporary staff. Legge (1989, as cited in Blyton and Morris, 1992) argued that flexibility could provide the adaptability that organizations may desire and still provide that competitive advantage when policies that promote commitment are also introduced.

Blyton, Heery and Turnbull (2011) argued that the managerial process is a critical factor in an employee's overall experience of work – including access to rewarding and fulfilling jobs, fair treatment, having the scope to develop skills and the involvement in decision making – opportunities that may not always be available to temporary staff. These work experiences hinge on how the workforce is managed, and if various forms of temporary employment are introduced, then management must focus on the employment relationship and their experiences of work to ensure high performance. Druker (2002) argued that organizations had the managerial responsibility for all the personnel whose productivity and performance they rely upon, and that productivity of individuals depends not only on the environment in which they are placed, but how they are managed and motivated. Employment contracts and relationships establish terms of an exchange between the employer and employee. The employment relationships of temporary staff may then need to be reconsidered or managed differently in comparison to their permanent counterparts in order to ensure suitable levels of organizational commitment and productivity throughout the period for which they are employed at the organization.

Social exchange theory was discussed by Blau (1964) as a type of exchange that develops between employees and their organization. The underlying rationale of social exchange theory is the development of trust in a relationship, so that obligations to each party are fulfilled to strengthen the social exchange (Shore, Coyle-Shapiro and Tetrick, 2012). A lack of balance in the fulfilment of the obligations might lead to negative consequences for the organization or the individual (Shore and Barksdale, 1998). In other words, employers and employees should feel obligated to reciprocate the actions of the other party to create a balance in the exchange relationship. Social exchange theory has been influential for understanding workplace behaviour (Cropanzano and Mitchell, 2005) and has been used in the development of the framework of the psychological contract. There has been a rapid growth in interest surrounding the psychological contract, following the work by Rousseau (1990, 1995) who's original definition of mutual obligations between the employee and the organization has since been developed to include the employer's perspective, considered to be essential to understand the full nature of exchanges of those involved in the psychological contract (Guest, 1998; Guest and Conway, 2002). The framework of the psychological contract was used in an international study (PSYCONES) examining different employment contracts (comparing temporary and permanent contracts) and employee well-being (Guest, Isaksson and De Witte, 2010). The psychological contract as an example of social exchange will be used in this thesis when discussing the management of temporary employees and their impact on patient safety and service quality.

De Cuyper, et al., (2011) argue that temporary employment is becoming a fixture in many organizations. As a result, employing organizations must respond to the human resources issues and challenges that using temporary staff can bring (Burgess

and Connell, 2006; Stanworth and Druker, 2006) and attempt to find strategies that could reconcile differences between employer and employee perspectives (De Cuyper, et al., 2011). If human resource managers wish to promote high involvement and high performance working environments, usually achieved through high levels of job security, job development and employee autonomy (Hall, 2006), characteristics not usually associated with temporary contracts, then the management of temporary employees and the temporary employment relationship will have to be reconsidered to ensure that organizational productivity can be maintained when temporary staff are recruited. As a first step in this process, we need a better understanding of current approaches to the management of temporary staff.

1.5 Patient safety and the Risk Management Perspective

Patient safety has been defined by the National Patient Safety Agency (NPSA) (2004) as a process, specifically a process by which organizations can make patient care safer. This process involves risk management, reporting errors, and learning from mistakes. The NPSA (2004) stated that patient safety should concern everyone in the NHS. Patient safety has become an international priority (Battles and Lilford, 2003). This followed the seminal report from the USA – ‘To Err is Human’ (Institute of Medicine, 1999), which indicated that patient care is not as safe as it could be and implied that at least 40,000 and perhaps as many as 98,000 people could die in American hospitals each year as a result of medical errors. Waring (2005) reported a UK perspective; in the NHS, mistakes or adverse events could be experienced in approximately 10 percent of inpatient admissions, with the human cost of up to 40,000 lives a year, also adding to the financial burden of the NHS.

The Department of Health (2006b), admitted that patient safety is a challenge for the NHS, and although the profile of patient safety has been raised, it may not have always received the same status as other pressing NHS issues. For some, the main impetus for the development of clinical risk management could be the rise in costs of litigation, arising as a result of clinical negligence (Walshe, 2001). Traditionally, efforts to control errors in medicine have focussed on front-line patient-facing medical practitioners. All humans will make errors and these can sometimes reflect characteristics of the organizations in which the care is delivered, thus error prevention could be aided by looking at the systems within which individuals work (Thomas and Biennan, 2001).

Vincent (1997) believed that risk management had the potential to act as a gateway into improving patient safety. No medical treatment is risk free, but patient safety should be recognised as the first dimension of quality of care. Walshe (2001) broadly defined risk as an exposure to events that could threaten or damage an individual and their interests, and that risk management has three main stages: identifying risk, analysing risk and controlling risk. Moss (1995) argued that the main aim of risk management was to reduce the likelihood of errors occurring – especially errors that could cause damage or discomfort to a patient. It was concluded that if risk management was linked into other quality initiatives, this could lead to the development of a coherent approach to quality improvements within a hospital. For risk management systems to work, the information gained through the identification and analysis of the events must be used to make future decisions as to how to control the risk (Walshe, 2001).

The Operating Framework for the NHS in England 2010/2011 (Department of Health, 2009), argues that improving quality was a key focus of healthcare

organizations, and the policies outlined in the framework are intended to ensure this focus on quality occurs and encourages risk management across systems. However, a decade after the Department of Health (2000b) published ‘An Organisation with a Memory’ reporting on the extent of clinical error and identifying that risk management systems should be implemented to reduce these figures, the NHS is still trying to establish ways in which the risk management of patient safety and improved quality of care can be achieved.

In summary, patient safety and risk management have emerged as key topics for research as a result from seminal documents from the USA: “To Err is Human”, and from the UK: “An Organisation with a Memory”. These publications highlighted how patient safety incidents may go unreported, and if patient safety is to improve, then risk management processes should be encouraged to report, control and reduce patient adverse incidents. If patient incidents are reported then there is the opportunity to learn from errors to minimise risks. However, this focus on risk management has generally failed to take into account the implications of using temporary staff, how they distinctively affect risk and how these risks should best be managed. Consequently, this thesis aims to explore the employment and the management of temporary staff, the risks associated with their use for patient safety and service quality and how these risks can be minimised. These issues will be explored within an analytical framework that builds on exchange theory, and more particularly, the psychological contract, focusing distinctively on the management of the psychological contract of temporary staff.

1.6 Research Aims and Objectives

This research uses the framework of the psychological contract to explore the ‘deal’ and employment relationship between those who hire and manage temporary staff and temporary employees. There will be a particular focus on the Emergency Department as when rapid decisions and effective communication is vital for effective and high quality patient care, the management of temporary staff is of heightened importance. Within this, the study aims to identify the perceptions about the management of the psychological contracts of those involved in the human resource management decisions with regards to the employment of temporary staff and the advantages or disadvantages this may have in relation to patient safety and service quality. This thesis will also identify management perceptions of individuals who are the main users/managers of temporary staff at a clinical ward level, as well as those who work alongside temporary staff. This research takes into account different types of temporary employment previously identified in hospital settings to acknowledge the heterogeneity of temporary employees in healthcare, and explore whether employment relationships with management or ‘the deal’ with these different forms of temporary staff vary. This thesis aims to extend the literature beyond the nursing population that has been extensively studied in the temporary employment in healthcare literature by including the perceptions of managing those at consultant level. As well as contributing to the literature on the management of temporary employment and patient safety, this research also has potential practical implications. Specifically, this research aims to identify methods by which the management of risk could be improved where temporary staff are involved.

1.7 Organization of this document

Chapter one: Introduction. This chapter has provided a broad introduction to the main issues of the thesis and the research aims and objectives.

Chapter two: The Management of Temporary Employment and its Consequences: A Review. This chapter provides a more extensive review of the literature regarding temporary employment, including a discussion about the organizational use of temporary employees, why individuals undertake temporary employment, and the resulting impact for organizational and individual. The chapter introduces the theoretical framework of the psychological contract through which the employment relationship of temporary staff will be discussed.

Chapter three: The Management of Temporary Employment in Healthcare. This chapter focuses on temporary employment in healthcare, why temporary staff are used, how temporary employees may impact patient safety and service quality, and difficulties in studying temporary employment in healthcare. Chapter three includes the research aims and the research questions.

Chapter four: Methodology. This chapter outlines how the research was conducted, including a discussion of the methodological approach undertaken, an outline of the two empirical studies and the healthcare settings, the sample used, how the data was collected and the data analysis approach.

Chapter five: Findings from Study 1: The Management of ‘Typical’ Temporary Staff in Emergency Departments. This chapter presents the results from the interviews with managers from the macro, meso and micro levels regarding the management of temporary staff and the implications for patient safety and service quality in the Emergency Departments of 2 London hospitals.

Chapter six: Findings from Study Two: The Launch of Major Trauma Centres in London. This chapter presents results from the Major Trauma Centre Study, which focused on an atypical form of temporary staff – the Consultant Resident On-Call for Major Trauma at a London hospital.

Chapter seven: Discussion of Findings. This chapter provides an integration and full discussion of the findings.

Chapter eight: Conclusions. This chapter highlights the key findings and contributions of the research, discusses any limitations and presents ideas for future research.

Chapter 2: The Management of Temporary Employment and its Consequences: A Review.

2.1 Introduction

The purpose of this chapter is to review research regarding the management of temporary employment and its consequences for individual and organizational outcomes. The term ‘temporary employment’ is widely used and a number of definitions have been developed. These will be explored in this chapter. The chapter reviews theories explaining why organizations use temporary employees, taking into account recent developments in legislation and the impact this could have on management decisions. The chapter also reviews the literature regarding the effects (both positive and negative) that temporary employees can have on organizational and individual outcomes and discusses why individuals may undertake temporary employment, as this could influence organizational outcomes.

The concept of the psychological contract as a form of social exchange will be introduced as a way in which organizational and individual workplace behaviours and outcomes have been studied. This will include an analysis of the psychological contracts of temporary staff and how the psychological contract should be managed.

2.2 Temporary Employment

This section discusses two of the complications in the research on temporary employment – the lack of a standardised definition and its heterogeneity.

2.2.1 Definitions of temporary employment

De Cuyper, De Jong, De Witte, Isaksson, Rigotti and Schalk (2008) noted how international studies of the growth of temporary employment have been hampered by the difference in vocabulary used and the absence of a universally accepted definition of temporary work. Data collection and analysis can also be hampered when there are different ways of defining temporary employment (Purcell and Purcell, 1998).

A definition of temporary employment commonly offered in texts was developed by the OECD in 2002, and refers to temporary employment as “*dependent employment of limited duration*” (De Cuyper, Mauno, Kinnunen, De Witte, Mäkikangas and Nätti, 2010, page 40). This is opposed to permanent employment which is open-ended (De Cuyper, De Witte and Van Emmerik, 2011). Although this definition aids international comparisons of temporary employment, caution still must be exercised when discussing the heterogeneity of the temporary workforce (De Cuyper, et al., 2008). The definition provides some clarity in comparison to the definitions previously offered.

The vocabulary used to describe temporary employment differs internationally, with the term ‘contingent employment’ being a popular description in the USA and Canada (Connelly and Gallagher, 2004). Polivka and Nardone (1989) noted how the term was first used to explain the notion of work being conditional on an employer’s need for labour and that temporary employment was transitional in its nature, with ‘contingent employment’ being defined as “*conditional and transitory employment relationships as initiated by a need for labour – usually because a company has an increased demand for a particular service or product or technology, at a particular place at a specific time*” (page 10) .

Polivka and Nardone (1989) argued this definition could lead to misclassifications of some employment conditions and there was an implied lack of attachment between the employee and the organization. They proposed an alternative approach for the definition of temporary employment based, in their opinion, on its most salient characteristic, job insecurity, and that a definition should include the classification of whether there is an expectation of future employment and not the actual duration of a relationship. The authors proposed a definition of ‘contingent employment’ as: *“Any job that does not have an explicit or implicit contract for long-term employment or one in which the minimum hours worked can vary in a non-systematic manner”* (page 11). The authors note that in many jobs, scheduled working hours may vary for a number of reasons (e.g. availability of other workers), but stressed that it was the unpredictability of the hours that should be termed contingent. De Cuyper et al., (2008) note that in European literature, the terms fixed-term, temporary and non-permanent are often used interchangeably but can vary in meaning.

Polivka (1996) and Garsten (1999) believed the transitory nature was a common characteristic by which temporary work could be defined, so that a temporary worker was somebody, *“In a job currently structured to be of limited duration”* (Polivka, page 4). Garsten (1999) stated that *“Temping, is by definition (at least) transitory”* (page 605). Rogers (1996, as cited in Garsten, 1999) believed that this transitory nature was essential in characterising a temporary job, *“No matter how long or short a temporary assignment lasts, a temporary job is just that – temporary. Sooner or later, the assignment will end and a new one will begin”* (page 605). Kirk and Belovics (2008) also highlighted the transitory notion when they described

temporary employees as those employed to fulfil jobs for limited and specific amounts of time.

Another theme in the literature when defining temporary employment is its ambiguous and insecure nature. Garsten (1999) noted that temporary employees may lack the structured bond between the employer and employee that is created by ongoing regular employment. Krausz (2000) believed temporary work could have minimal job security, continuity and predictability, whereas Boyce, Ryan, Imus and Moregeson (2007) highlighted the ambiguous nature in terms of job location, job requirements and not knowing what the supervisors or co-workers would be like.

Some have attempted to define temporary employment, by indicating how it departs from the permanent, traditional or standard employment relationship (Gallagher and McLean Parks, 2001), characterised as employment with work on a full time basis with a single employer. Other ways in which temporary employment contracts may differ from the standard employment relationship is through the lack of benefits and entitlements offered to the workers, and the possibility of employment arrangements being market mediated (De Cuyper, et al., 2008). Thus work arrangements that fall outside this 'standard employment' bracket can be classed as alternative or temporary employment. Casey (1988) had previously questioned whether a comparison with permanent or standard employment is a suitable way to define temporary employment due to the questionable ideal of the concept of 'normal' working hours and suggested looking at particular forms of temporary employment conditions, instead of attempting to formulate a general definition.

The heterogeneity of temporary employment is reflected in the different categories of temporary employment that have been identified in the literature. One of the most

common and identifiable forms is employment through a temporary employment agency (Gray, 2002). The distinctive characteristic of temporary agency employment is the triangular relationship between the employer, employee and temporary work agency (Burgess, Rasmussen and Connell, 2004; Claes, 2005; Van Breugel, Van Olffen and Olie, 2005). The temporary agency acts as the intermediary between the temporary employee and the host organization. The host organization provides the temporary worker with the roles they are to perform and what they consider to be the necessary supervision, while the temporary agency is the individual's legal employer and pays their salary (Liden, Wayne, Kraimer and Sparrowe, 2003). This work arrangement means the individual's employment relationship fulfils obligations to more than one employer through the same act of behaviour (Van Breugel, et al., 2005; Gallagher and McLean Parks, 2001).

Fixed term contracts are another form of temporary employment. Casey (1998) defined fixed term contracts as employing individuals for a pre-determined period of time, with Bernhard-Oettel, Sverke and De Witte (2005) adding that those employed on fixed term contracts are usually taken on for the duration of a specific project, or as a temporary replacement, for example, maternity leave and had roles and attitudes comparable to those employed on permanent contracts.

Independent contractors (individual employees who can sell their services to an organization for a specific project) have become increasingly visible in certain industries (Connelly and Gallagher, 2004). Casey (1998) included seasonal work as a form of temporary employment, where workers are hired to meet seasonal peaks in demand, especially in industries such as tourism and agriculture. Guest, Isaksson and De Witte (2010) noted a number of temporary contracts that occur as a result of probationary periods, training arrangements or national job creation schemes, and

those employed by consultants or by subcontractors, may appear from an organizational perspective to be temporary, with a relationship only being maintained until the end of the assignment. Others questioned the need to constantly re-categorise alternative forms of employment as this could become increasingly difficult with new flexible work arrangements arising in a response to changes in the work environment (McLean Parks, Kidder and Gallagher, 1998).

On-call work can also come under the umbrella of temporary employment, as it is undertaken on an as needed basis, where workers need to be available at certain times and may be called into work when required by their employer (Eurofund, 2007). It can involve unpredictable and irregular working hours, and can occur in a variety of settings, but is particularly common in healthcare.

Pearce (1993) and Matusik and Hill (1998) reasoned that due to the heterogeneity of temporary employment, generalisations should not be made about temporary workers, and stereotypes should not be transferred from one temporary worker to another, as the terms of the temporary contract, and how they are interpreted by the individual could differ and may influence behaviour (McLean Parks, et al., 1998; Engellandt and Riphahn, 2005). It is for this reason that the specific form of temporary contract must be noted when researching temporary employment contracts. How the various forms of temporary contracts are managed by the organization must also be considered since this could affect organizational outcomes.

The definition of temporary employment to be used throughout this thesis will be that developed by the OECD, “*dependent employment of limited duration*”. Although this definition does not provide a distinction between the range of temporary employment contracts discussed above, it does indicate its transitory

nature and highlight its limited duration. The definition also provides a basis for comparing temporary employment across a range of occupational settings.

2.2.2 Demographics of temporary employment

The various definitions and interpretations of temporary employment have led to difficulties in measuring its prevalence (Forde and Slater, 2001). Guest (2004b) reported that the extent of growth in the temporary contract was dependent upon the definition used, but alarmist reports forecasting the end of ‘traditional employment’ are wide of the mark. As Forde and Slater (2006) highlight, even though the overall pattern of temporary employment in the UK seems stable, one form of temporary employment – temporary agency employment – had, at one stage experienced rapid growth. They reported that in the period between 1992 and 2001, the number of individuals working through temporary employment agencies increased by 346 percent to stand at 281,000. The temporary agency employment figures peaked in 2001, and since this date the proportion of those undertaking temporary employment through temporary employment agencies began to decline (Forde, Slater and Green 2008). The authors reported that currently, fixed-term contracts account for the most common form of temporary contract in the UK.

Forde and Slater (2006) reported that in comparison with many EU countries, the proportion of temporary employees in the UK and the USA was low. De Cuyper, et al.,(2008) noted that the incidence of temporary employment in Europe varies from 4 percent in Luxembourg, up to 35 percent in Spain, with the average incidence being about 15 percent. The OECD (2002) reported that there had been no universal trend towards an increasing level of temporary employment.

Efforts have been made to profile those who undertake temporary employment. Tan and Tan (2002), when providing an empirical analysis of temporary workers in Singapore, suggested the profile of temporary workers has become more variable as a result of changing market conditions and the increased use of temporary employees in professional and technical fields. An earlier US study by Feldman, Doeringhaus and Turnley (1994) found that temporary workers were most likely to be housewives with children in school, students, those voluntarily out of full-time employment and those who are unable to find permanent employment. Forde, Slater and Green (2008) used a full year of British Labour Force Survey data in an attempt to define the characteristics of the agency workforce, in comparison to permanent workers, and other forms of temporary staff (including fixed term contracts). Over half of the agency workforce was male (57 percent), and over half of those occupying fixed term contract positions were female (52 percent). Seasonal or casual temporary jobs were more likely to be held by younger age groups, and agency workers, in comparison to those on fixed term contracts, were relatively young. Those in temporary agency employment had a similar education status to permanent workers. Those on fixed term contracts were the most likely of all the groups to be educated to degree level. This adds to evidence suggesting fixed term employment contracts are used by those who have specific skills that some organizations are looking for to undertake or complete certain projects.

There is evidence indicating that temporary employees can be found in almost every role in organizations, although the work they are given to undertake whilst in the temporary position is changing (Wheeler and Buckley, 2000; Foote, 2004), and more occupations are now using temporary employees (Gossett, 2006). When discussing occupational patterns of temporary workers, Forde and Slater (2005) found that fixed

term contracts were increasingly used for professional, associate professional and technical organizational positions, although permanent workers were still likely to occupy management practices. Temporary agency work was still associated with lower skilled occupations, and was over-represented in secretarial, semi-skilled process jobs and unskilled elementary jobs. The authors noted that there was little evidence that temporary employment was undertaken to facilitate family responsibilities.

In summary, temporary employment can come in many forms, but is often used as an umbrella term to include employees employed through temporary employment agencies, fixed-term contracts, seasonally hired employees and on-call employment. It is therefore important that the heterogeneity of temporary contracts is kept in mind when discussing the use, management and outcomes of temporary employment for the organization and individuals. Temporary employment in UK is relatively low in comparison to other EU countries, however, its presence in many organizations has led to increased interest in the management and consequences of temporary employees.

2.3 The organizational use of temporary employees

Over the last few decades, researchers have noted how the nature of the workforce in organizations has changed (Kalleberg, 2009). What was considered the normal or standard work arrangement (i.e. work that was performed full time, continued indefinitely, and performed under the supervision of an employer) is now gradually changing and there is a concern about the loss of stable/predictable careers and the rise of non-standard contracts (Hendry and Jenkins, 1997; Connelly and Gallagher,

2004; Broschak, Davis-Blake and Block, 2008), an umbrella term that includes temporary employment. This non-standard, or flexible form of employment is not necessarily new, but the growth of flexible employment worldwide has attracted considerable interest (Kalleberg, 2009).

Debates about why organizations have introduced temporary employees have focussed around various components of flexibility. Numerical flexibility has often been cited as a reason for the organizational use of temporary staff (Forde and Slater, 2006, Wheeler and Buckley, 2000, Connelly and Gallagher, 2006). Reilly (1998) defined numerical flexibility as a form of flexibility that: *“Allows the numbers of staff used to vary according to the needs of the business”* (page 9), with Walsh and Deery (1999) adding that numerical flexibility allows for a response to unanticipated changes in the business environment. In an attempt to avoid the restrictions and the consequences associated with volatile economic market conditions, temporary staff can be called in (and dismissed) at short notice (Foote and Folta, 2002, Matusik and Hill, 1998) for the necessary period of time or for the duration of a project. This flexibility could be *“The firm’s ability to manage its capacity more efficiently”* (Matusik and Hill, 1998, page 682). Alternatively, functional flexibility offers adaptability if there is change in the product market, by allowing for flexibility in the crossing of occupational boundaries and multi-skilling (Pollert, 1988). Functional flexibility allows for improved labour deployment when adjustments are needed to fit changes in product or task demand (Pollert, 1988, Reilly, 1998).

Numerical and functional flexibility formed the core components in the flexible firm model, which attempted to model trends in the restructuring of the labour force (Atkinson, 1984), with the aim of providing flexibility to respond to unanticipated changes in the business environment and fluctuations in business demand (Walsh

and Deery, 1999). The model assumes a dual labour force composed of a stable core of skilled employees (notably those in managerial and professional positions, and multi-skilled employees), with a peripheral buffer, including temporary staff, providing numerical flexibility (Pollert, 1988). Some observers have suggested this distinction may be too simplistic. Walsh and Deery (1999) argued that temporary workers can constitute a core strategic component in an organization, and temporary staff should not be viewed as supplementary to the workforce, an argument also put forward by Ward, Grimshaw, Rubery and Beynon (2001), who claim their presence may also change the culture and dynamics of the workplace. De Cuyper, Notelaers and De Witte (2009) highlight the importance of acknowledging the heterogeneity of temporary employment, arguing that as a result of the different guises of temporary employment, the core-periphery model needs re-structuring. For example, in some organizations those on fixed-term contracts work closely with core workers and undertake similar roles, yet in the flexible firm model they would be considered as peripheral.

Other evidence to suggest the core-periphery model may be too crude a distinction, especially in relation to functional flexibility, stems from the argument that the contemporary role of temporary workers in organizations is dramatically different than in previous decades (Foote, 2004). Temporary staff were originally limited (and can still be limited in certain circumstances) to replacing relatively unskilled positions and covering absence (Purcell, Purcell and Tailby and Campus, 2004). However, temporary staff can now increasingly be seen to fill a variety of positions including professional and managerial positions and those requiring extensive knowledge and technical skills (Foote, 2004). Matusik and Hill (1998) suggested that temporary staff, in certain contexts, can be a means of accumulating and

creating valuable knowledge. Not only does temporary employment allow for easier access to external knowledge, but it also allows for rapid dissemination of the firm's knowledge outside its boundaries. Temporary employees may be able to acquire public knowledge from other organizations they have worked at that they can bring into an organization (Szabo and Negyesi, 2005) leading to the organization developing a competitive advantage. Temporary workers can be used as technical experts for certain projects, and they can specialise in bringing best practices into individual firms (Matusik and Hill, 1998).

Von Hippel, Magnum, Greenberger, Heneman and Skoglund (1997) believed that temporary employees allowed organizations greater flexibility in the distribution of the work force, especially during a restructure, or during fluctuation in organizational demands. Temporary employees could be moved to different departments, or experience changes in job description. It was argued this was more feasible than using permanent workers, as a job change was less likely to be a violation to an implicit or explicit contract. Deery and Mahony (1994) noted when researching the employment policies of retailing firms, temporary staff were more likely to be willing to work unsocial hours if necessary. However, this would only be the case upon the payment of higher rates associated with working these hours. This creates a management challenge, ensuring that organizations have strategies to flexible employment, yet simultaneously ensuring that those providing the flexibility are satisfied with the job to provide organizational commitment for high service provision.

Lepak and Snell (1999) recognised that not all employees possess knowledge and skills that are of equal importance to an organization, and organizations should use different employment modes to allocate work, revolving around decisions to

internalise and strengthen the organization's skill base through training and development programmes, or to externalise employment and outsource certain functions.

Lepak and Snell (1999) developed a theoretical human resource architecture with four different employment modes: internal development, acquisition, contracting and alliance. They proposed HR employment choices should be based upon value (skills that can improve an organizations efficiency and effectiveness, particularly in contributing to the competitive advantage or core competence of the firm) and uniqueness (the firm specificity of the skills that an individual is able to offer) (Lepak and Snell, 1999, page 35). When value and uniqueness are both high, the model proposes internal development, as the firm specific skills are unlikely to be found in the external labour market. These employees are perceived to be core to the organization, developing an organization-focussed relationship, with the notions of long-term involvement and investment being key to the employment relationship. Conversely, when uniqueness and value are low, the skills needed by an organization can be found easily in the labour market, and organizations may reduce employment costs by contracting externally. This can be done without concerns for an organization's competitive position. Temporary employment (as it is typically perceived) can fall into this category, as external individuals complete tasks that contribute little to an organizations competitive position, yet provide organizations with a level of flexibility regarding how many, and when employees are hired. The relationship can be viewed on a more transactional basis, with the individual having limited association with a firm, not expected to take on broader responsibilities and have limited opportunities for training.

There are some examples of research that attempt to validate this model. Lepak and Snell (2002) investigated 148 firms and their HR employment practices in attempt to ascertain whether value and uniqueness of skills were considered. The results provided support for the model, with the researchers concluding that value of human capital was reflected in choices regarding internal vs. external employment practices, and the level of skill uniqueness differentiated the likelihood of transactional vs. relational employment contracts. As a result, HR practices may have to differ depending on the employment mode adopted. Lepak, Takeuchi and Snell (2003) argued it was too simplistic to suggest that one particular employment mode is superior to other employment options and in some situations, organizations may benefit from both internal and external employment arrangements. They researched whether different employment modes can have implications for an organization's performance in relation to the flexibility they provide, specifically focussing on co-ordination flexibility and resource flexibility. Results indicated that the employment mode used by firms is significantly related to an organization's performance. The organizations that relied on both knowledge based workers and contract workers displayed higher performance than those that only relied on one of the employment modes. Organizations which made use of employment modes that accounted for both coordination and resource based flexibility showed beneficial performance outcomes.

Peel and Boxall (2005) used the Lepak and Snell model to look at employment choices from two perspectives: managers making choices of employment structures to meet the needs of their firms, and workers making work arrangements to meet their particular needs. They concluded that organizations tended to contract out for low value work which required little uniqueness, and in some cases externalised

work that was highly specialised but only needed at certain periods. Both Lepak, Takeuchi and Snell (2003) and Peel and Boxall (2005) show there may not be a single best way of employing staff in an organization, but a consideration of the employment modes, and the organizational context is necessary.

Financial flexibility has been discussed when considering the organizational use of temporary employment. Reilly (1998) believed that financial flexibility allowed wages and any other associated benefits to rise and fall with economic conditions. Martens, Nijhuis, Van Boxtel and Knottnerus (1999) stated that from a managerial and economic perspective, temporary employment practices could have a number of advantages (for example, strengthening specific categories of workers, decreasing the workforce when necessary). Rodriguez-Gutierrez (2006) noted that in times of uncertain economic conditions, organizations would create temporary employment contracts, characterised by decreased severance payments, and the ability to cancel contracts without the risk of appeals procedures. Biggs, Burchell and Millmore (2006) add that organizations may use temporary workers in economically strategic ways as they may be paid substantially less in direct wages or benefits than permanent workers. Wheeler and Buckley (2000) viewed the use of temporary staff as a human resource management strategy to reduce overhead costs and increase flexibility without compromising the productivity of the firm. Temporary workers may also be hired to avoid increasing the wages of permanent workers (Galup, Saunders, Nelson and Cerveney, 1997). Peel and Boxall's (2005) research discussing management employment decisions questioned whether financial flexibility should be added to Lepak and Snell's framework (1999), as some organizations may have internalised some employment roles not due to its competitive value, but as a result

of its relative infrequency. External employment could be used due to the need for organizational financial flexibility.

Parker, Griffin, Sprigg and Wall, (2002) extend the financial flexibility argument, adding that temporary workers result in lower costs at the recruitment, training, fringe benefits and severance stages of a contract in comparison to permanent contracts. Fringe benefits that organizations do not have to supply certain temporary workers include: company pensions and bonuses, company sick pay and holiday pay (Gray, 2002). Legislation has been introduced in the UK specifying that employees on fixed-term contracts have the right to be treated as comparable to permanent employees in the same organization. If the employee has been engaged in successive fixed-term contracts for four years or more with the same employer, they are also entitled to permanent employment in that organization, and dismissal solely on the grounds of avoiding a fixed-term employee becoming permanent is viewed as a breach of regulations (The Department of Trade and Industry, 2002).

With regards to temporary agency employment legislation in the UK, since October 1st 2011, temporary agency workers are entitled to equal treatment after 12 weeks in the same job (calendar weeks are accrued regardless of how many hours the worker does on a weekly basis). This includes key elements of pay (holiday pay, overtime and bonuses linked to performance), and other entitlements such as annual leave, night work (if relevant) and similar rest periods as those recruited directly by the organization. From their first day in placement, agency workers must have access to facilities such as childcare, the canteen and access to information regarding job vacancies in the organization (Department of Business, Innovation and Skills, 2010, 2011). Consequently, some of the original financial flexibility arguments (especially concerning the differences in fringe benefits, pensions and contract severance) may

not be as applicable to certain forms of temporary employment and may not provide the lower costs discussed in some literature. The impact of the new UK legislation on management decisions to use temporary employees is yet to be seen.

Wiens-Tuers and Hill (2002) focussed on training as an organizational benefit, and according to the human capital perspective, argued firms should only have the incentive to invest in training when they expect a return that is greater than the original cost. The return on investment in training declines if employees have a short tenure with a firm. Organizations using temporary employees may save on training costs especially when the skills needed are generic (Purcell, et al., 2004). Burgess, Rasmussen and Connell (2004) note that organizational use of temporary agency staff transfers the training costs onto the temporary agencies and the temporary workers (although this could mean that training may not occur at all). To reduce training costs, organizations may also use temporary workers who are specialised in the field (Wheeler and Buckley, 2000), or trained elsewhere (von Hippel, et al., 1997), especially if this is more cost-effective than training permanent workers.

Temporary contracts could be used by organizations as a recruitment device, the temporal flexibility of contract length being used to determine whether the employee is suitable for the organization (Booth, Dolado and Frank, 2002), similar to the idea of a probation period or screening tool before offering a permanent position (Wheeler and Buckley, 2000). Hiring temporary workers can consequently reduce selection costs (von Hippel, et al, 1997). However, monitoring of performance may increase to ensure candidate suitability (Hall, 2006). Forde and Slater (2005) argued that performance monitoring of temporary staff can be reduced if agencies were efficient at screening and matching the workers they provide organizations, thus

increasing the probability of the temporary employee's suitability to the host organization.

Research has indicated indirect benefits of temporary employee use that influence organizational productivity. Using the basic underlying premise of the core/periphery model, Geber (1993) argued that an advantage of using temporary staff was the security it could provide permanent employees. If an organization using temporary workers faced a business downturn, permanent staff were unlikely to become unemployed, as an organization would be increasingly likely to sever temporary contracts. However, this would only apply if the core workforce was relatively stable. Permanent workforce productivity may increase as they may have the opportunity to focus on core organizational competencies, while temporary staff focus on more peripheral and easily monitored tasks with clear performance expectations (von Hippel, et al., 1997; De Cuyper, et al., 2010), allowing for efficient resource use (Kalleberg, 2003). The presence of temporary employees could improve permanent workforce productivity, especially if they anticipate a risk to job security (Foote and Folta, 2002). However, temporary workers may provide a distraction for permanent workers if they require increased supervision to undertake tasks.

Some research suggests that temporary workers may display less absence from work as a result of sickness. Virtanen, Kivimäki, Elovainio, Vahtera and Cooper, (2001) observed that temporary employees had a significantly lower rate of sickness absence than permanent staff, even after family relations, occupational groups, work hours and schedules were controlled for, potentially as a result of attempting to impress managers to become permanent, for contract renewal and to reduce negative perceptions of temporary workers from management and fellow employees. Ichino

and Riphahn (2005) conducted research on employee absenteeism during and after the temporary probationary period. Once the probation period ended, the average number of days absent was always higher (for men) than during the probation. Absenteeism increased immediately after full protection was granted.

Isaksson, Peiró, Bernhard-Oettel, Caballer, Gracia and Ramos (2010) researched reasons for undertaking flexible employment from the employer's perspective. A pilot study had identified a list of twelve possible reasons for employing temporary workers. Management representatives in over two hundred organizations across seven countries rated these in terms of importance for their organization as part of the PSYCONES study. Results indicated the most commonly cited reasons for hiring temporary workers were to fill vacancies during maternity leave or other long-term permanent staff absences. Meeting peaks in demand and recruiting individuals for trial periods before offering permanent contracts were the second and third factors identified. Cost reductions as a result of savings through fringe benefits, training and salaries were among the least prevalent reasons for hiring temporary workers. The management representatives from the United Kingdom reported substitution-related items as the main reason for temporary staff use, with maternity cover, matching peaks in demand and covering short-term absences all rated equally, followed by vacancies that organizations were unable to fill.

In summary, the advantages of various forms of flexibility have been offered as explanations for organizational use of temporary employment. The flexible firm model is commonly cited in literature focusing on a stable core and a flexible peripheral workforce. Although this model helps to explain numerical and functional flexibility, concerns have been raised regarding the simplicity of the model, and the crude core/periphery distinction. In some situations 'peripheral' staff

are required to provide specific information, skills or knowledge that are core to the organization, indicating that the model could be further developed to include the heterogeneity of temporary staff. Lepak and Snell (1999) developed a framework where this heterogeneity was discussed using differences in the uniqueness and value of human capital, providing four employment modes with varying levels of internal and external flexibility. The model, which noted that external employees were sometimes required, but were not necessarily peripheral to the organization's needs, has received some empirical support. Financial flexibility has been offered as an explanation for the organizational use of temporary staff, as when economic conditions fluctuate, temporary contracts can be used as a method of reducing severance payments and expenditure on fringe benefits. However, with the introduction of legislation for fixed term contracts and temporary agency contracts regarding equal treatment in the UK, this argument may now hold less weight.

2.4 Why do individuals undertake temporary employment?

Peel and Boxall (2005), claimed that a majority of the literature addressing temporary employment use came from an organizational or management perspective. However, others have presented different views of flexible employment, including the concepts of knowledge workers and career self management, suggesting that an increasing number of workers are asserting control over their working lives and choosing where, for whom, and what type of employment contract they work (Guest, Oakley, Clinton and Budjanovcanin, 2006). Greater knowledge of temporary workers and an understanding of their motives and attitudes are necessary, since this could influence their performance and the effectiveness of human resource

management strategies. With the diverse temporary workforce and many types of temporary contract, reasons for being a temporary worker are likely to be varied, and may reflect the social and economic nature of the labour market (Tan and Tan, 2002).

De Cuyper and De Witte (2008) distinguished between voluntary and involuntary reasons for undertaking temporary employment. They defined voluntary temporary workers as those who enter the work arrangement willingly, even though they have the chance to seek permanent employment. Voluntary motives include the opportunity to combine work and non-work roles, for example choosing a work pattern allowing for family obligations leading to a reduction of role conflicts (Krausz, Brandwein and Fox, 1995; Casey and Alach, 2004; Gannon, 1984), and gaining experiences within different tasks and jobs (De Cuyper, De Witte, Krausz, Mohr and Rigotti, 2010). When researching temporary employment in Singapore, Tan and Tan (2002), noted that women tended to leave the workforce after having children, and temporary work became an attractive option allowing for flexibility in scheduling work and family responsibilities. Temporary employment therefore suits individuals looking for an employment pattern that best fits their current situation (Felfe, Schmook, Schyns and Six, 2008). Involuntary motives for temporary employment usually refer to the difficulty of finding or gaining permanent employment (Tan and Tan, 2002). De Cuyper and De Witte (2008) argued that volition should be considered as this fosters the perception of choice and control over employment situations. De Cuyper, et al., (2010), investigated individual and organizational outcomes of employment contracts using the PSYCONES data. They found voluntary motives for choosing temporary employment were positively related to job satisfaction and negatively related to irritation and anxiety. When taking the

temporary roles as a pragmatic option (as a result of not having a permanent job), this was associated with job satisfaction.

Economic incentives have been used to explain the choice to work temporarily. Gray (2002), using Labour Force Survey data, observed some occupations where temporary work (especially through an agency) could be more profitable than permanent employment, especially when temporary workers were used to fill specific skill shortages. Economic incentives for undertaking temporary employment were also noted in relation to taking on a second role, alongside a permanent position (Tan and Tan, 2002). In this way, temporary employment allowed individuals to work for added economic gains without having to give up a permanent job.

For some, temporary employment is a personal preference. Burgess, Rasmussen and Connell (2004) argued that it allowed for a high degree of independence, the opportunity to work in a variety of organizations and interesting roles, especially for temporary workers with skills in high demand, as they could exercise a degree of control over when and for whom they work. Korpi and Levin (2001) noted that individuals may become temporary employees to gain information regarding potential employers and employment conditions. Through temporary placements, individuals can gather information and experiences about wages and how their qualifications are rewarded in different situations. Temporary workers have the advantage of not being heavily involved in organizational politics and interpersonal conflicts that can affect permanent employees (Foote and Folta, 2002; Garsten, 1999). They may also be subject to fewer work pressures than their permanent equivalents (Green, 2008). Tan and Tan (2002) theorised that temporary workers at the lower end of the employment spectrum had reduced authority and responsibility,

were less likely to be accountable for important decisions and would feel less stressed. Krausz (2000) examined differences in employee outcomes between voluntary and involuntary temporary agency employees, finding that if individuals were in a situation with the ability to choose their work and potentially their employment contract, they will have increased intrinsic motivation, greater freedom, and the opportunity to withdraw from the environment when it became increasingly stressful.

Others have hypothesised that temporary work could act as a stepping stone to permanent positions (Tunny and Mangan, 2004), or as a means of maintaining an income while searching for permanent positions (Morris and Vekker, 2001). Even if temporary contracts fail to develop into permanent opportunities, they may still serve as relatively continuous forms of employment (Korpi and Levin, 2001). By undertaking temporary employment, networking opportunities could be made available to the individual, especially important for those aiming for more permanent positions (Tregaskis, 1997). De Cuyper, Notelaers and De Witte, (2009) added that temporary employment could be an opportunity for the worker to show their motivation and skill suitability. The stepping-stone or foot in the door motivation for undertaking temporary employment and the hypothesis that this could lead to high standards of performance as employees attempt to show constructive attitudes and the image of a valued employee was explored in the PSYCONES study (De Cuyper, et al., 2010). The results indicated that the 'stepping stone' motive was positively related to organizational commitment and sickness presence.

However, there is some evidence to suggest that temporary employment could lead to an employment trap. Amuedo-Dorantes (2000) reported with respect to work transitions that temporary workers were 42 times more likely than permanent

workers to be in a temporary position a year later, whether in the same or in a new temporary position. It was concluded that in many cases temporary employment did not facilitate the employee's mobility to a more permanent position. Additionally, temporary employment could become a trap where the individual could find themselves in a cycle of temporary employment. This research was conducted in Spain where temporary employment covers approximately 33 percent of the workforce, and Amuedo-Dorantes (2000) realised that, "*Given the peculiarities of Spain's institutional, economic and legal framework, these results could be specific to the Spanish labour market*" (p. 324). Forde and Slater (2001) used the Labour Force Survey reports on annual transition rates, and found that of those temporary workers remaining in employment one year later, half of them were in temporary positions. The authors concluded that, "*By this measure, temporary work is a "trap" for at least as many workers as it is a "bridge" to permanent employment*" (p. 22). Those undertaking temporary employment should be aware of this trap, but Forde and Slater failed to recognise that some individuals choose to undertake temporary employment on a permanent basis, and would not consider their position as a trap.

Evidence exists to support the conventional assumption that many individuals undertake temporary employment involuntarily. Booth, Francesconi and Frank (2002b) provided results to confirm the common perception that temporary jobs are not desirable when compared to permanent employment, but may have to be undertaken as a means to an end. Morris and Vekker (2001) investigated why people choose temporary jobs, reporting that 67 percent of those currently in temporary employment wanted a permanent position with the common response given for working temporarily being the inability to find a permanent post. The

evidence suggested that flexibility and experience played a much smaller role than factors such as limited permanent job opportunities. Green (2008) also noted that all things being equal, employees would prefer to have a permanent contract, but temporary employment is often viewed as better than unemployment (Kalleberg, 2000). De Cuyper, et al., (2010) used the PSYCONES data to identify involuntary motives for undertaking temporary employment. Two items were identified to factor into involuntary motives: 'the difficulty of finding a permanent position' and 'it was the only type of contract I could get'. The authors also reported that two-thirds of the sample wanted permanent jobs.

In summary, the literature recognises that temporary employment occurs not solely as a result of organizational needs, but the individual also plays an important part. The evidence demonstrates that some temporary employees may choose to work under temporary contracts, as a result of family responsibilities and the need for flexible work schedules. Others may choose temporary employment to gain experience in a variety of organizations, increase networking opportunities, have greater autonomy in their roles and reduced involvement in organizational politics. Some may undertake temporary employment hoping this could lead to a permanent position in an organization, or because they are unable to find permanent employment (thus involuntarily becoming temporarily employed). Others have questioned whether temporary employment provides the flexibility in work scheduling and work roles often cited in literature. For example, Lowry (2001) when exploring the impact of flexible or 'casual work arrangements' from the perception of the workers reported that flexibility in scheduling was viewed as being based upon employer flexibility, to the exclusion of employee flexibility. Similarly, Davidson (1999) when providing evidence from temporary workers who felt their

rights were being overlooked reported the flexibility of roles when working for an organization can be limited, and therefore dependent on what the organization has to offer the temporary worker. What needs to be determined is whether the reasons for hiring temporary employees have implications for employee and organizational outcomes.

The following section discusses the outcomes of both organizational and individual choices to undertake temporary work, and presents the analytical framework for the thesis. Methodological issues relating to the research into temporary employment and how these could explain some of the findings are discussed.

2.5 The Management of Temporary Employment

Guest (2003) noted the growth in various forms of employment flexibility, and their application in industry and suggested there is need to understand its implications for both the organization and the individual. By using temporary staff, organizations can respond rapidly to changes in business conditions with relatively little effort or time, but questions have been raised as to whether their use actually provides an advantage to an organization. In organizational environments where employment flexibility has become increasingly popular, if not necessary to maintain organizational productivity, how the temporary employee's and organizational relationship is managed and maintained is important to ensure minimum disruption to organizational output. This thesis uses the framework of social exchange theory, and in particular the psychological contract to explore the employment relationship between temporary employees and the organization, and how its management affects organizational outcomes.

2.5.1 Social Exchange and the Psychological Contract

Cropanzano and Mitchell (2005) described social exchange theory as among the most influential conceptual paradigms for understanding workplace behaviour (page 874). Social exchange involves a set of interactions that generate obligations, but these interactions are contingent upon the actions of another person. Such interactions have the potential to result in high quality relationships. Blau (1964, as cited in Shore, Coyle-Shapiro and Tetrick, 2012) suggested these relationships can fall into two broad categories: economic exchange and social exchange. Economic exchange relationships were characterised by both parties fulfilling specific obligations of a formal contract on which the exchange is based (Shore, et al., 2012). They are short-term and usually involve the exchange of concrete resources (Rupp and Cropanzano, 2002). Social exchange relationships are based upon unspecified obligations, with the nature of the return of the exchange left to the discretion of the respective party. In this way, social exchange relationships need time to develop the trust that obligations will be discharged, serving to strengthen the social exchange (Shore, et al., 2012). A long-term relationship is necessary for the development of trust and the giving and receiving of benefits between both parties in the exchange.

Schalk, de Jong, Rigotti, Mohr, Peiró and Caballer (2010) noted that social exchange theorists considered the employment relationship to be an exchange. Rhoades and Eisenberger (2002) suggested that in exchange for organizational benefits such as wages, fringe benefits and positive working conditions and perceived organizational support, employees display loyalty and effort towards organizational goals and outcomes. Rupp and Cropanzano (2002), argued that when employees perceived fair treatment by an organization they would respond with increased organizational citizenship behaviour, commitment and fewer turnover intentions, in comparison to

those perceived to be unfairly treated. Social exchange theory is based upon the 'norm of reciprocity' (Gouldner, 1960), where commitments and contributions made by one party then obligates the other party to provide appropriate returns (Dabos and Rousseau, 2004). Schalk, et al., (2010), stated that the exchange relationship would develop if the reciprocity of positive obligation is perceived by both parties involved. Conway and Briner (2005) believed the notion of reciprocity is central to social exchange theory; what is given and received in return should be roughly similar, and the ongoing fulfilment of obligations allows a relationship to develop. Over time, this relationship will become trusting, loyal and mutual (Cropanzano and Mitchell, 2005).

Social exchange theory has been influential for understanding workplace behaviour (Cropanzano and Mitchell, 2005), and has been used as a framework for exploring the employee-organization relationship, including the development of the concept of the psychological contract. The psychological contract between an employer and employee can be defined as *'the perceptions of both parties to the employment relationship – organization and individual – of the reciprocal promises and obligations implied in that relationship'* (Guest and Conway, 2002, as cited in Guest, Isaksson and De Witte, 2010, p. 17). Schalk, et al., (2010) add that the psychological contract specifies what the two parties are expected to give and receive from each other in an exchange relationship. These perceptions of exchange are created on both the employer and employee's side. The notion of reciprocity in the psychological contract is important, since if it was not present, it would be difficult to regard the psychological contract as a 'contract' (Conway and Briner, 2005). Shore, et al.,(2012) add that the norm of reciprocity is central to explaining why fulfilment of the psychological contract is related to outcomes, as the

discrepancy between what is promised and what is fulfilled provides the basis upon which employees reciprocate. The psychological contract, as one form of the exchange relationship, has been used as a lens or analytical framework through which organizational and individual workplace behaviours, outcomes and attitudes have been explained.

Herriot, Manning and Kidd (1997) argued that different representatives of an organization may have different messages regarding their expectations and obligations, and consequently an employees' perceived contract with an organization can be unclear. A greater understanding of the content of the psychological contract is therefore needed to maintain a stable employment relationship for positive organizational outcomes. If employees perceive the content of their psychological contract to be broken or unfulfilled, employees may reduce their commitment, motivation or morale towards the organization (Herriot, et al., 1997). Using a critical incident technique, the authors concluded there was considerable agreement about the obligations from both parties (e.g. employers to provide training, a safe work environment, fairness, recognition for good work, whilst employees display loyalty, honesty and work their contracted hours). The authors concluded that given the fundamental agreement between both parties as to what the elements of the contract are, the main issue when discussing psychological contracts is a consideration of what a 'fair-exchange' is, with both parties demonstrating they can keep deals to develop and maintain mutual trust and commitment.

The degree of communication between parties at the initial negotiation stages may lead to fewer misunderstandings as to the nature of the contract (Herriot and Pemberton, 1996, 1997), thus the process of communicating the psychological contract could be as important as balancing its content in terms to contributing to

successful management practices (Guest and Conway, 2002). Guest and Conway (2002) found that senior HR managers who reported more extensive use of communication also reported clearer and less breached organizational contracts and promises, as well as a fairer exchange and a more positive impact of policies and practices on employee attitudes and behaviours. Thus, how the employment relationship is communicated and effectively managed can affect organizational outcomes, especially if trust is developed.

McLean Parks, et al., (1998) stated that psychological contracts specified how an employee defined a deal, and whether or not they believed that the deal had been honoured. The psychological contract allows for the exploration of the processes and contents of the employment relationship, and how this relationship changes over time (Guest, 2004b). The notion of reciprocity is closely associated with trust, as it is assumed that trust emerges when the promise-based obligations are fulfilled by the other party, and when the exchanges are perceived to be fair (Schalk, et al., 2010). Guest and Clinton (2011) when discussing trust and HRM note there is a general assumption that HR practices are among the key organizational factors that can help shape the content and fulfilment of the psychological contract, and can also play an important role in building trust. In their study, the PSYCONES data was used to explore the relationship between HRM, the psychological contract and trust, and their impact on outcomes associated with individual well being (job satisfaction and work related anxiety-contentment) and the organization (organizational commitment and intention to quit). The results demonstrated a strong association between the presence of more HR practices and a more fulfilled psychological contract, but also a strong association between more HR practices and higher levels of trust and fairness.

The HR practices were also strongly associated with the outcomes measures, thus benefiting both the individual and the organization.

However, Guest and Clinton (2011) demonstrated that fulfilment of the psychological contract was also associated with the four outcomes – with job satisfaction and lower intention to quit having the strongest association with fulfilment of the psychological contract. One of the constructs in the psychological contract in terms of explaining employment relationship outcomes has been contract breach (Conway, Guest and Trenberth, 2011). Contract breach occurs when one partner in a relationship perceives another to have failed to fulfil promised obligations (Robinson and Rousseau, 1994). Rousseau (1989) stated that a defining feature of psychological contract breach was that once a promise had been broken it was difficult to repair. A violation of the psychological contract is the extreme affective or emotional reaction that may accompany breaches (Conway and Briner, 2005). A breach is the perceived discrepancy between what was promised and has been delivered, and a violation is the emotional reaction that can be experienced when a serious breach has been perceived.

Perceptions of breaches were found to be significantly associated with the decline in employee obligations (intention to remain with the organization, in-role and extra-role performance) and employee well-being (job satisfaction) (Robinson, Kraatz and Rousseau, 1994). Conway, et al, (2011) when investigating differential effects of psychological contract breach and fulfilment concluded the negative impact of breach on attitudes was significantly stronger than the positive impact of increased fulfilment. These findings are important when partnered with research highlighting managers' failure to fulfil promises made to employees. For example, Guest and Conway (2002) found that senior managers responsible for policy making

acknowledged a partial or complete failure to keep some of their promises and commitments. More recently, the PSYCONES study reported that both the employer and employees perceived that employers are less likely than employees to keep their promises and commitments (Schalk, et al., 2010). This has management implications: if a perceived breach in the psychological contract occurs, this could lead to negative outcomes for the organization if the individual reduces their organizational commitment or increases their intention to quit. Managers should try to avoid breaches occurring and ensure employees perceive contract fulfilment.

McLean Parks, et al., (1998) highlighted the need for an increased understanding about the psychological contract in non-standard employment arrangements. They argued that as a result of differences in the nature of temporary contracts, it is difficult to make inferences regarding the attitudes and behaviours of temporary employees (and how these can differ from permanent employees in the same role), and the psychological contract may be a useful tool to help understand or predict temporary employee behaviours.

Whether the psychological contracts of temporary and permanent employees differ has been subject to debate and research. Rousseau (1990) in a study using students recently recruited to permanent positions, demonstrated two forms of contract, transactional and relational, associated with the expected length of stay of the employee at the organization. The transactional relationship was comprised of short-term exchanges with concrete and economic transactions in comparison to the relational contract which focused on a long-term perspective, raising expectations for future developments. The latter are generally seen to be more beneficial. Using this distinction, temporary workers are thought to have a short-term, transactional exchange relationship with the organization in comparison to permanent employees

(McLean Parks, et al., 1998). Distinctive characteristics of the exchange relationship of temporary employees include: narrower psychological contracts and contracts that are tangible and easily observable (McLean Parks, et al., 1998). Temporary employee contracts have been defined as more transactional or economic in their focus and less socio-emotive (Rousseau, 1995) in comparison to permanent (relational) contracts, due primarily to the short-term nature of temporary employment contracts and the limited time available to form attachments to the organization. As a result of being narrower and more explicit in focus, the contracts are less easily breached (Rousseau, 1995).

Schalk, et al., (2010) in the PSYCONES project, explored the contracts of temporary and permanent employees to test whether the assumptions in the literature outlined above are supported. They concluded that temporary workers did have narrower psychological contracts than permanent workers (with temporary employees both receiving and making fewer promises to employers in comparison to permanent staff). In terms of the fulfilment and reciprocal nature of promises, temporary employees reported a greater level of fulfilment of promises by the organization and higher levels of trust and fairness, consequently reporting lower levels of psychological contract breach and violation than permanent employees. Permanent employees reported that the relational items of the psychological contract were least likely to be fulfilled, suggesting that permanent employees would evaluate their psychological contract more negatively than temporary employees. When employed for longer periods of time, there is increased opportunity for exchanges to occur, but also an increased opportunity for contract breach, influencing the overall evaluation of the psychological contract. When there is a wider psychological contract, there is also greater opportunity for psychological contract breach. Results for the employer-

employee exchange relationship suggested employees perceived they made more promises and fulfilled them to a greater degree than employers, and employers broadly agreed with this. Temporary staff were more likely to report that both the promises made by the organization and those they made had been fulfilled, with permanent staff reporting lower fairness, trust and increased violation of their psychological contracts than temporary staff.

Research into the psychological contract as a means of understanding employment relationships has grown in popularity, alongside the view that organizational changes and flexible employment contracts have eroded the ‘traditional relationship’ of job security in return for organizational commitment (Sturges, Conway, Guest and Liefvooghe, 2005). These changes can create challenges for human resource managers and line managers (Hiltrop, 1995) as questions arise as to how new ‘deals’ in these dynamic situations can be secured in order to maintain organizational loyalty, productivity and commitment. Hendry and Jenkins (1997) argued that organizations may still expect high commitment and trust from employees when contracted in transactional-based relationships. Consequently, there is a need for more active and effective management to redefine the ‘deals’ that employees have at work, and further appreciation about how perceived changes in the ‘deal’ are experienced by employees.

In summary, the context of the organization, their strategies, structures and processes will determine what organizations expect from their employees and what they feel they can offer them (Herriot and Pemberton, 1996). However, the organizational and management perspective on the psychological contract has been relatively under-researched in comparison to studies focussing on individual outcomes of psychological contract negotiation and breach (Guest and Conway, 2002; Herriot

and Pemberton, 1996). In particular there is limited knowledge about management's motives and preferences when taking on and seeking to establish a short-term relationship with temporary staff. This thesis aims to study the management of the psychological contract of temporary staff in an attempt to begin to fill this gap.

2.6 Organizational Outcomes of Temporary Employment

The following section reviews research discussing organizational outcomes of using temporary staff. However, there are apparent inconsistencies within the literature, and explanations about why this occurs are provided at the end of the chapter.

2.6.1 Performance, productivity and behavioural outcomes

Organizational productivity and quality of service could reduce when temporary workers are employed, as they may take time to learn about the organization and the nature of the role they are undertaking. For example, in his review of emerging research on various temporary work arrangements, Kalleberg (2000) suggested that the productivity of temporary workers may be lower than that of permanent workers, as they are new to the role and have to learn the processes associated with the tasks. Nollen (1996) provided examples of case study research where productivity was objectively measured for temporary workers, finding that it was lower than core employees undertaking the same role. In a case study examining the issue of temporal flexibility in a retail firm, Deery and Mahony (1994) concluded on a cautionary note that if increasingly flexible employment policies resulted in greater job dissatisfaction, this could result in lower organizational commitment and a poorer quality of customer service. Foote and Folta (2002) discussed whether

temporary workers provide organizations with 'real options' when undertaking work investment decisions, suggesting that productivity of temporary workers may be inhibited if organizations failed to provide a suitable induction. These outcomes are partially supported by research conducted by Van Dyne and Ang (1998) who, when comparing temporary and regular employees, found temporary staff engaged in less organizational citizenship behaviour. This could be explained through the limited nature of exchange associated with temporary work. When employed in a temporary position for a short period of time, individuals are likely to have fewer benefits and are perceived to be less attached to the employing firm. Consequently temporary staff may display less organizational citizenship behaviour towards the organization. Van Dyne and Ang (1998) concluded that the behaviour of temporary employees is contingent upon their attitude towards their employment relationship; if they do not view their psychological contract positively, they may withhold positive organizational citizenship behaviour.

Productivity may be reduced as a result of limited training. Connell and Burgess (2006) stated that few temporary agencies provided training and consequently some temporary staff would not possess or would struggle to maintain market relevant skills. Temporary employees may have to find training for themselves to retain the skills they needed for employment, and this leads to questions regarding how skill development for temporary employees occurs when they enter a new organization or role. Organizations may be reluctant to provide training to temporary staff if they are only at an organization for a short period of time, as the time and money invested in the training will not be recouped by future productivity (Geary, 1992). Consequently, it may prove harder for temporary staff to keep relevant skills up to date. With regards to professional development, Gossett (2006) in a qualitative

study of temporary agency workers reported that they do not receive performance feedback or evaluations usually used to guide future performance and corrective behaviour. Additionally, temporary workers reported that they were seldom fully integrated into the host organization, and often found themselves working with limited supervision. Gossett (2006) recognised this was a particular limitation for temporary agency workers, as the agency had limited contact with the worker, and no easy way to monitor an employee's performance. As a result, temporary employee's mistakes or limited productivity are not necessarily detected.

De Gilder (2003) reported research comparing temporary and permanent employees performing the same roles on a number of measures, including job behaviour (loyalty, organizational citizenship behaviour, neglect). Results indicated temporary workers showed fewer positive job behaviours towards an organization in comparison to the permanent employees (temporary employees displayed less loyalty, and increased exit and neglect behaviours). Supervisors also reported that temporary employees displayed less organizational citizenship behaviour than permanent employees. Attitudinal measures (commitment) were reported to correlate with behavioural measures, employees reporting high commitment reported more positive behaviours (loyalty and organizational citizenship behaviour). The author concluded that employees performing the same roles although employed on different contracts may differ in their organizational behaviour. De Gilder (2003) explained these findings by referring to the differences in employment relationships between permanent and temporary employees. With a weaker or more detached relationship, it can be argued that temporary workers may feel they do not have as much to profit from the employer in the long run, and adjust their behaviour accordingly, harming the effectiveness of the organization. The research was

conducted in an organization where the level of service was important to customers, and the author argued that customers might be less likely to receive a high level of service from temporary workers in comparison to permanent workers.

However, other research concerning the organizational behaviours and productivity of temporary staff has displayed mixed outcomes, indicating that the pattern of results does not allow for firm conclusions to be made (Bauer and Truxillo, 2000; De Cuyper, et al., 2008). For example Engellhardt and Riphahn (2005) found temporary employees provided increased organizational citizenship behaviour and productivity in comparison to permanent employees. Individuals employed in temporary positions reported significantly more unpaid overtime hours in comparison to permanent employees. The type of temporary contract can also influence organizational performance, for example, Chambel and Castanheira's (2006) results comparing the behaviours of permanent, fixed term and temporary agency employees indicated that permanent and fixed-term contract workers engaged in more organizational citizenship behaviours than those employed through temporary agencies. However, temporary agency workers also reported that the organization offered them fewer inducements in comparison to those employed through fixed term contracts and permanent workers. The authors concluded that the variable contract is an important factor when considering employees' organizational behaviours.

The PSYCONES study found that behavioural indicators such as performance, sick leave, accidents and incidence of harassment and violence did not differ between temporary and permanent staff (De Cuyper, et al., 2010). Temporary workers when compared to permanent employees reported lower turnover intentions and sickness presence. Intention to quit was influenced by violation of the psychological contract.

If permanent employees perceived the use of temporary employees violated their contract, then satisfaction decreased, and they reported a greater intention to quit in comparison to temporary staff (Guest and Clinton, 2010). Guest and Clinton (2010) also found that self-reported performance was associated with the fulfilment of promises to the employer. The authors concluded that type of employment contract was associated with job satisfaction and intention to quit, but not with performance. When discussing the organizational performance and productivity of temporary staff, other factors have to be included. The findings also indicated the effects of temporary staff use on permanent staff satisfaction, and the influence on their intention to quit. Exchanges between permanent staff need to be included when conducting research regarding the employment and management of temporary staff.

In summary, research discussing the performance, productivity and behavioural outcomes have indicated mixed results. Productivity and behaviour could be lower in comparison to permanent employees as a result of the limited exchange that organizations provide temporary employees. However, level of productivity and behavioural outcomes have also been shown to be dependent upon the type of temporary contract the employee is hired on, thus the heterogeneous nature of contracts must be taken into consideration. The psychological contract, as a way of viewing the nature of exchanges and contracts between the employer and temporary employee may therefore be a useful framework through which to consider organizational outcomes when using temporary employees.

2.6.2 Organizational commitment

Connelly, Gallagher and Gilley (2007) reported that a number of authors had examined the commitment of temporary workers to client organizations with the common assumption that temporary contracts are associated with lower levels of organizational commitment (De Cuyper, et al., 2008; De Gilder, 2003). Galais and Moser (2009) stated that the concept of organizational commitment, including stability, loyalty and the feeling of being part of an organization could stand in contrast to the nature of temporary employment. Others have argued that the various foci within organizational commitment may not be relevant to the different forms of temporary contracts as a result of temporary employees varying links to an organization and limited on-going relationship with the employer (Connelly, et al., 2007). Meyer, Allen and Topolnysky (1998) provided definitions of three common conceptualizations of commitment: affective commitment (an emotional attachment to, identification with and involvement in the organization), continuance commitment (a perceived cost associated with discontinuing employment) and normative commitment (a belief there is a moral obligation to remain with an organization) (page 83).

De Gilder (2003) studied organizational commitment of temporary staff in comparison to permanent staff, with temporary workers displaying reduced affective organizational commitment than permanent employees. Forde and Slater (2006) reported evidence of lower commitment from temporary agency workers, with little loyalty or pride in the organization, and agency workers less likely to report a strong desire to stay at the organization in comparison to permanent staff. Van Dyne and Ang (1998) suggested temporary workers had lower affective commitment in comparison to permanent employees with fewer opportunities to develop

organizational attachments, and they perceived fewer employer obligations. Another potential explanation for the findings is that lower affective commitment was based on feelings of inequity in terms of reduced training benefits and job security. This can be related to the employment relationship – if temporary employees perceive they are not receiving additional benefits from an organization, to balance the exchange, temporary employees may display less commitment towards an organization. Gallagher and McLean Parks (2001) provided evidence suggesting a positive exchange between employers and employees could lead to commitment towards the provider organization. For example, as temporary workers needed access to current skills, then skill development through training offered by the client firm could enhance the temporary employee's commitment.

However, there is evidence to counter these arguments. De Witte and Näswell (2003) when studying organizational commitment in four countries, found no differences between temporary and permanent employees in the Belgian, Italian and Swiss samples, while in the Netherlands temporary employees scored higher than permanent workers in the level of organizational commitment displayed. De Cuyper and De Witte (2007) looked at the impact of job insecurity and commitment in both temporary and permanent employment contracts and found that when permanent workers had an increased perception of job insecurity then the level of organizational commitment was reduced. Results were explained in reference to the psychological contract. Job insecurity is perceived to breach the relational psychological contract, impairing the work relationship for permanent workers, with employees altering behavioural and attitudinal responses to the organization accordingly. With job insecurity expected in the temporary relationship, this may have little effect on the level of commitment displayed by temporary staff. Similar findings were also

reported by McDonald and Makin (2000) where temporary staff indicated significantly higher levels of affective and normative commitment than permanent staff.

The PSYCONES study also examined organizational commitment. The analysis of attitudes and behavioural outcomes among temporary and permanent employees revealed there were no differences between the contract types on organizational commitment (De Cuyper, et al., 2010). Clinton and Guest (2010) noted that organizational commitment was strongly associated with the fulfilment of promises and obligations by the organization. Commitment was greater among those whose psychological contract had not been violated. Thus, organizational commitment may be dependent upon some form of exchange relationship and the specific focus of temporary or permanent employment may be less important.

In summary, organizational commitment was thought to stand in contrast to the nature of temporary employment, with the common assumption that contracts of limited duration were associated with lower levels of organizational commitment. However, research findings comparing the commitment of temporary and permanent employees have led to inconsistent results. Attempts have been made to explain these findings in relation to the psychological contract, with findings suggesting that organizational commitment was associated with the fulfilment of promises and obligations by the organization. Thus how the employment relationship is managed may impact the level of organizational commitment displayed by employees.

2.6.3 Knowledge transfer and team development

Other organizational impacts regarding temporary staff use have centred around knowledge transfer and team development, and how this may affect organizational productivity. Gruenfeld, Mannix, Williams and Neale (1996) researched group composition and decision making, noting that the effectiveness of group decision processes had become an increasingly common organizational concern, and as a result of growing demands, teams were becoming more commonplace for task completion. The researchers concluded that groups with familiar members were more effective at pooling information and integrating a variety of different perspectives when making decisions, than groups whose members were not familiar with each other. Familiar groups were also more open to learning from one another. Those unfamiliar to groups may have the knowledge to add to decision making activities, but lack the social ties and interpersonal knowledge regarding other group members to add input. Chattopadhyay and George (2001) studied the impact of having mixed contract statuses in organizational work groups using the theoretical framework of social identity – the process by which individuals maintain a positive social identity through categorisation. Social identity and esteem was enhanced when the in-group was compared favourably to the out-group. Smith (1994) had previously noted that a distinction between temporary and permanent employees, and employees categorise themselves upon such in-group and out-group dimensions. Chattopadhyay and George (2001) found that temporary workers perceived their jobs to be of lower prestige than permanent workers. However, when permanent workers found themselves in a minority, work status and prestige dissimilarity negatively affected outcomes such as trust and altruism towards temporary workers. Thus, it is important to consider group distinctions and organizational trust, and how this

affects knowledge transfer, and organizational behaviour. A lack of trust between temporary and permanent employees can have serious implications for knowledge transfer between these two groups of workers, having implications for the management of temporary staff (Connelly and Gallagher, 2006).

Nahapiet and Ghoshal (1998) discussed organizations as social communities with the capability of creating and sharing knowledge. Under such circumstances social capital develops, allowing access to information and development opportunities. Social and informational transfer are conditional upon situations where relational trust is high, where there is a norm of co-operation and where there is strong group identification. The use of temporary staff can reduce opportunities for knowledge transfer as time is important for the development of social capital, and disruptions in group stability (as a result of the temporary nature of contracts) may disrupt the ability to form trusting relationships. However, as temporary workers may come to the organization with specific knowledge, care must be taken to ensure this is not lost when temporary workers leave (Bidwell, 2008). Matusik and Hill, (1998) described this as the competitive advantage of using temporary workers but theorised that this would be moderated by an organization's ability to integrate information and apply the knowledge that temporary staff can bring. This creates implications for human resource management, and how temporary staff should be integrated into an organization to maximally benefit from their knowledge, skills and abilities (Connelly and Gallagher, 2006; Ward, Grimshaw, Rubery and Beynon, 2001; Foote, 2004).

2.6.4 Financial outcomes

Matusik and Hill (1998) note that for some organizations, temporary employment may not always be a cost saving option. In some cases, the hourly premium paid for temporary staff may be higher than that for permanent staff. They suggest a cost equation should be conducted by a firm to calculate the value of hiring temporary staff; including an assessment of the hourly wages of both temporary and permanent staff (including base wages, benefits, training and recruitment costs), the value of having an increasingly efficient management of staff capacity and the value of having staff flexibility, against the premium paid for temporary work. Biggs, Burchell and Millmore (2006) suggested that the use of temporary workers as a cost reduction strategy as a result of reduced wages (either directly or through a reduction of benefits), may be negated as a result of reduced productivity, and the time needed to recruit temporary staff. In a pilot study researching the costs involved in staff turnover and the use of temporary staff, Gray, Phillips and Normand (1990) argued the losses incurred whilst temporary staff reach the productivity of permanent staff should be considered. Costs for the added burden on human resource management to ensure that temporary staff are monitored properly are not included in estimates for the costs of temporary staff use.

In summary, research has provided inconsistent results regarding organizational outcomes when using temporary staff. For example, research indicates that in some cases temporary staff displayed reduced performance, productivity and commitment in comparison to permanent employees in the same roles. However, there is also evidence to suggest the contrary, and that temporary staff could be beneficial for organizational outcomes. Explanations as to why inconsistencies in the results have been found are discussed later in the chapter.

2.7 Individual outcomes of temporary employment

As discussed previously, individuals undertake temporary employment for a variety of reasons. This section discusses the effects of temporary employment for the individual. If individuals perceive that they are well-treated by organizations, then in accordance with social exchange theory and the psychological contract, this should lead to positive employee attitudes and behaviours towards the organization, which could translate to positive organizational outcomes. It would therefore seem important to ensure that the psychological contracts of temporary employees are managed appropriately.

2.7.1 Job satisfaction and well-being

There is a sizeable and growing body of research exploring the relationship between types of employment contract and various aspects of worker well-being. Beck (2000) defined the growth in various forms of flexible employment as shifting the risk from the employer to the individual, indicating that as a result, temporary workers could be viewed as marginal and disadvantaged (Guest, 2004a), with temporary workers potentially experiencing reduced employee well-being and job satisfaction in comparison to permanent employees. Wheeler and Buckley (2000) examined the motivation of temporary employees discussing how individuals in some temporary employment situations described themselves as feeling isolated and having little control. This came from a lack of power over their work, maintaining work relationships and being unable to define themselves in the organization. Garsten (1999) identified the 'just a temp' notion; the feeling of not belonging, or having the freedom to engage in social relations in the workplace. Feldman,

Doeringhaus and Turnley, (1994) added that temporary employees in their study reported feeling discouraged by the impersonal way they were treated (little respect and courtesy). These findings add to the conventional assumption that temporary employment has negative outcomes for those undertaking it (De Cuyper, et al., 2010).

When discussing the well-being of temporary employees, one variable that has received increased attention is job satisfaction. However, research exploring whether temporary employment results in greater job-dissatisfaction in comparison to permanent employment have proved inconclusive (De Cuyper, et al., 2008). There is a plethora of research indicating that job dissatisfaction is greater amongst temporary employees. Benavides, Benach, Diez-Roux and Roman (2000), concluded that job dissatisfaction was consistently and positively associated with temporary employment, when compared to full-time employees across a sample that covered 15 countries in the EU. Forde and Slater (2006) found that temporary agency workers reported lower satisfaction in comparison to permanent employees on a number of variables including hours worked, relationships with supervisors, promotion and job security, and temporary agency staff also reported dissatisfaction with pay. Lower satisfaction was also reported in terms of the scope of their role and the level of initiative they were able to apply to tasks.

Armstrong-Stassen, Al-Ma'aitah, Cameron and Horsburgh (1998) undertook a study looking at organizational support and job satisfaction, reporting that co-worker support is a significant predictor of satisfaction. If temporary workers had support from co-workers and permanent workers then satisfaction was displayed and turnover was reduced. Wilkin (2012) undertook a meta-analysis of research investigations comparing job satisfaction of permanent and contingent employees.

Results indicated that contingent workers as a group are slightly less satisfied with their employment in comparison to permanent employees. However, the different temporary employment contracts identified in the meta-analysis (direct hires, contractors and temporary agency workers) experience varying levels of job satisfaction (for example agency workers and direct hirers experienced lower job satisfaction in comparison to contract workers). Thus it is important to clearly specify the type of temporary contract studied when reporting results as satisfaction results between temporary contracts do vary. Wilkin (2012) also discussed the practical implications of the results, suggesting the importance of implementing or extending human resource practices to temporary workers so that they experience increased job satisfaction – especially salient to managers because differences in job attitudes may influence performance. The author concluded that organizations should treat temporary workers fairly to increase productivity, citizenship behaviour and decrease turnover.

McDonald and Makin (2000), De Cuyper and De Witte (2007) and Mauno, Kinnunen, Mäkikangas and Nätti (2005) all found that permanent staff had lower levels of satisfaction in comparison to temporary employees. In an attempt to justify these apparent contradictions, Parker, Griffin, Sprigg and Wall (2002) noted that although temporary staff reported negative job characteristics such as lower job security and limited roles in participative decision making, being a temporary employee was also associated with a perceived reduced workload and fewer strain-inducing role demands. This had the net effect of temporary employees reporting reduced strain and positive job satisfaction in comparison to permanent employees.

Another explanation for temporary staff reporting higher job satisfaction in comparison to permanent workers, are the implications of the reliance on temporary

staff affecting the perception of job satisfaction for permanent workers. Temporary employees may be hired when the workload is too high for permanent employees, implying that permanent workers may not be able to cope with the demands put upon them (De Cuyper, et al., 2010). Research suggests that permanent staff workload may paradoxically increase as a result of temporary staff use. Chen and Brudney (2009) indicated that managers delegated the training and supervision of temporary workers to permanent employees. Pearce (1993) found that temporary staff would receive easier tasks to complete, and extra monitoring tasks were undertaken by permanent staff to ensure that any mistakes made by temporary employees were covered and did not lead to further errors. It is therefore important to understand the impact temporary staff have on the permanent workforce (Flipczak, 1997), and manage any affects accordingly. Connelly and Gallagher (2006), reviewed the existing research literature on the implications of the changing nature of work, and what they termed 'contingent employment contracts', stating that organizational performance may be disrupted as permanent employees were less likely to offer assistance to a temporary employee who would not necessarily be at the organization long enough to reciprocate. If permanent employees perceived temporary employees received preferential treatment, they may begin to reconsider their position in the organization.

Increased use of temporary staff may reduce levels of organizational trust among permanent employees, especially if it leads to the laying off of permanent staff, the feelings of 'distributive injustice', and the belief they are compensated less than temporary workers who may perform less complex tasks and have a narrower contribution to overall organizational productivity (Connelly and Gallagher, 2006). Davis-Blake, Broschak and George, (2003) concluded that permanent employees

displayed an increased propensity to leave the organization, whilst reducing loyalty when temporary staff were introduced into the organization. The increased use of temporary workers heightened the permanent workforce's perception of job insecurity, and concerns regarding the permanent workers added responsibility (without increased financial reward) and reduced attention from managers. Pearce (1993) and George (2003) also found that permanent employees' perception of organizational trust reduced with the use of temporary workers, indicating that managers should consider how the employment of temporary staff could impact the productivity of the permanent workforce. Davis-Blake, et al., (2003) found that permanent staff in lower organizational positions regarded the threat to their ability to gain promotion in the organization to be greater, than those based in higher organizational positions when temporary staff were employed. Kraimer, Wayne, Liden and Sparrowe (2005) explored the role of full-time employees' perceived job security in explaining reactions to the use of temporary staff. Employees with lower levels of job security were more likely to attribute temporary staff use as intentional efforts by the organization to reduce costs through internal changes that threaten employees' jobs, and this was associated with fewer obligations for them to perform well.

George (2003) used the concept of the psychological contract to explain results regarding the use of temporary workers on permanent workers' attitudes and behaviours. The author argued that the use of temporary workers, and the (perceived) changes this may have on the permanent employee's individual job design and perceived job security was viewed as a violation of their psychological contract as (in her study) emotional attachment to the organization was weak and was negatively related to the employee's affective commitment to the organization.

Well-being for both permanent and temporary employees across seven countries was researched by De Cuyper, et al., (2010), as part of the PSYCONES study. The results indicated that in general, permanent employees reported poorer work related well-being when compared to temporary staff. Temporary workers reported significantly lower scores on irritation, anxiety and depression, but importantly they scored higher on job satisfaction when compared to permanent employees. The results of the PSYCONES study also indicated that permanent staff reported poorer health than temporary workers. Guest and Clinton (2010), when using the PSYCONES data suggested the psychological contract was an important variable when discussing well-being, most notably the experience of violation (associated with measures of depression, anxiety and irritation), and the employee's fulfilment of their promises and obligations to their employers. Permanent staff, having fulfilled their promises, were likely to experience greater violation if they perceived that their obligations had not been reciprocated by the employer. This was perceived more greatly than those on temporary contracts, as permanent employees had wider contracts, and could perceive a greater imbalance of exchanges. This perceived unfairness of the exchange is associated with lower levels of well-being. Guest and Clinton (2010) concluded that the element of the psychological contract most strongly associated with negative worker well-being was contract violation, while positive well-being was associated with the employee's perception of the fulfilment of their promises to the organization. When permanent staff perceived their psychological contract to be violated, this was associated with reduced perceptions of trust and fairness in the organization, especially when they believe they had fulfilled their own promises and obligations to the organization. This supports the

general view of increased demands on permanent workers and the social exchange theory that informs the psychological contract (Guest and Clinton, 2010).

In summary, conventional thinking would suggest that well being and job satisfaction would be reduced for temporary employees, especially if they would prefer to be in permanent employment and had little integration into the team environment they work in. However, once again, research comparing job satisfaction and well-being of permanent and temporary employees indicate a degree of inconsistency in findings, and the recent meta-analysis by Wilkin (2012) indicated that satisfaction levels vary between the different types of temporary contract identified in the literature. Although the relationship between job satisfaction and job performance is under debate (Judge, Thoresen, Bono and Patton, 2001), there is clear evidence of an association between job satisfaction and performance. However, the impact of temporary employees on the satisfaction of permanent staff must also be considered, especially if they are relied upon to undertake additional monitoring or supervisory tasks without receiving additional recognition. The framework of the psychological contract can be applied when considering individual outcomes of temporary employment. If temporary and permanent psychological contracts are not positively balanced, this could affect well-being and performance outcomes, which could translate into negative organizational outcomes. It is therefore important for managers to implement human resource measures to ensure positive psychological contracts for both temporary staff and permanent staff who work alongside them.

2.8 Explanations for inconsistent results

The previous sections have highlighted issues regarding temporary employment and its impact for both the organization and the individual. Inconsistencies in the research have been described and attempts have been made to understand why these differences have occurred (Connelly and Gallagher, 2004; De Cuyper, et al., 2008). One explanation is the lack of specification about the form of temporary employment used, complicating comparisons of expectations or experiences reported by different forms of temporary staff (Connelly and Gallagher, 2004; Wilkin, 2012). Dale and Bamford (1988) had previously stated that a clear definition of temporary employment has to be in use if research is to be of any value. De Cuyper, et al., (2008) and Moorman and Harland (2002) noted the heterogeneity of the temporary contract, the nature of volition and heterogeneity in terms of background factors (such as age, gender, education) should be taken into consideration when discussing results, as these could influence findings on notions such as stability, commitment, performance and perceived control.

Virtanen, Kivimäki, Joensuu, Virtanen Elovainio and Vahtera (2005) argued that the context in which temporary work is conducted should be accounted for, as the proportion of temporary staff in relation to the workforce being studied can affect outcomes, for both temporary and permanent staff. Contextual and background organizational features that could mask or inflate differences in employment contracts may not be controlled for (e.g. household income, number of children and work involvement) (Bernhard-Oettel, Isaksson and Bellaagh, 2008), and generalisations should not be made across occupations, as some organizations have work contracts designed specifically for temporary employees, tailored towards their specific requirements. De Cuyper, et al., (2008) note that multi-cultural research

studies can provide confusing responses due to differences in cross-cultural definitions of temporary employment and differences in legislation regarding temporary worker rights.

Kalleberg (2009) and Connelly and Gallagher (2004) mention the limited number of longitudinal designs when studying temporary employment. However, it was recognised that some forms of temporary contracts may in practice be difficult to approach from a longitudinal perspective; as a result of its nature, contracts can be short and there is high turnover. Longitudinal data would be helpful to understand whether attitudes formed during the temporary employment experience are sustained. If attitudes are variable, cross sectional measures may not provide reliable and accurate measures of the temporary working experience (Connelly and Gallagher, 2004). De Cuyper, Noteleers and De Witte (2009) conducted a two-wave study with a time-lag of eighteen months, so a comparison between different employment contract transitions could occur, attempting to discuss inconsistencies in research findings. Results concluded that continuous temporary employment does not lead to unfavourable outcomes over time. Those who remained on temporary contracts throughout the study reported no significant differences in work engagement or affective organizational commitment, suggesting that individuals may prefer temporary employment. Employees who transferred to a permanent contract after having been employed temporarily reported an increase in work engagement but no difference in affective organizational commitment, suggesting that if employment is gained in an employee's chosen field this could be increasingly beneficial for the employee rather than the organization. Somewhat surprisingly, those who became temporary after having a permanent contract reported higher affective organizational commitment and work engagement after the transition. The

authors proposed this could indicate dissatisfaction with their previous working conditions. There is still a need for further longitudinal studies to investigate the effect of temporary employment for organizational and attitudinal outcomes.

Finally, taking a more conceptual rather than methodological perspective to explain the apparent contradictions, researchers have noted that many organizational behavioural theories are based on 'traditional' forms of employment, and question their applicability to temporary contracts (Connelly and Gallagher, 2004; Connelly, Gallagher and Gilley, 2007; De Cuyper, et al., 2008; Gallagher and McLean-Parks, 2001). This has particularly been noted with respect to the various components of organizational commitment, as this may not seem immediately relevant to different forms of temporary contracts, especially those who feel tenuously linked to an organization (Connelly, et al., 2007). Theoretical perspectives have also been questioned as to their applicability to temporary contracts. For example; social exchange theory has been used to hypothesise reactions to fairness experienced by permanent and temporary workers (Van Dyne and Ang, 1998). However, the often short duration of temporary employment may provide little opportunity for an exchange relationship to develop (Connelly and Gallagher, 2004; De Cuyper, et al., 2008).

In summary, the lack of specification regarding the form of temporary contract used when researching the outcomes of their use has been offered as an explanation for the inconsistent results reported in literature, as well a limited acknowledgement of other organizational contextual factors leading to their use. The theoretical concepts used in an attempt to explain behavioural outcomes may not always be applicable to temporary contracts, leading to difficulties in theoretically discussing research

findings. This thesis attempts to address some of the methodological problems highlighted in previous research relating to temporary staff.

2.9 Chapter summary

Temporary employment has become a topic of increased focus in recent years as a result of the potential consequences of its use for both the organization and the individual. Debates as to why organizations use temporary staff have focussed on various components of flexibility and in some organizations, the necessity to have a full complement of staff to maintain productivity. The common assumption when discussing temporary employment and organizational outcomes suggests that those on shorter contracts would result in reduced performance, leading to questions regarding how temporary staff should be best managed so that performance outcomes are not compromised.

However, as discussed throughout the chapter, research discussing the effects of temporary employment at organizational and individual levels has revealed inconsistent outcomes (unaided by the lack of a standard definition of temporary employment). In organizational environments where employment flexibility has become popular, how the organizational relationship with the temporary employee is managed to minimise any disruption to organizational outputs needs to be understood. In this research the concept of the psychological contract as an example of social exchange is the lens through which the employment relationship and how it is managed is explored, with discussions revolving around relational (usually associated with long-term contracts) and transactional (short-term more temporary) contracts.

The use of temporary staff in organizations may indirectly affect permanent employees, leading to changes in the responsibilities or work design of permanent staff which could be viewed as breaching both their real and psychological contracts. Permanent staff may respond by reducing their productivity or re-assessing their contract with an organization. Thus, when researching the implications of temporary staff use, how the psychological contracts of permanent staff who work alongside temporary staff are managed must also be considered.

This research looks at the nature of the psychological contracts of temporary staff from a management perspective, determining whether this theoretical framework can be applied in a healthcare setting. There is a distinctive focus on healthcare as a result of the range of temporary staff found in one setting and the high use of temporary staff in the sector (in addition to the management dilemma of having to maintain service provision whilst reducing staff spend). The next chapter discusses the use and management of temporary staff in healthcare specifically, and the implications of temporary staff use for patient safety and service quality.

Chapter 3: The Management of Temporary Employment in Healthcare

3.1 Introduction

This chapter discusses the use and management of temporary staff in healthcare. This includes: a short discussion of staffing in the NHS, providing an explanation regarding why temporary staff are needed in the NHS, definitions of various forms of temporary staff in hospital settings and a focus on the literature highlighting the implications of temporary staff use for patient safety and service quality. The chapter concludes by bringing together the review of the general temporary employment, and temporary employment in healthcare literature and introduces the aims and research questions the thesis aims to answer.

3.2 Quality and Efficiency

The NHS has a challenge to ensure healthcare is safe for patients and to provide a strategic framework for improving patient safety (Sandars, 2005). Over 10 years ago, the National Health Service's (NHS) Plan (Department of Health, 2000a) emphasised the need for quality improvement and the minimisation of errors in patient care. The plan focused upon patient needs and establishing procedures leading to improved care, whilst simultaneously recognising that NHS staff are an important resource. 'An Organization with a Memory' (Department of Health, 2000b), set out plans to reduce the effects of adverse events on patient safety. The goal of quality improvement is still at the forefront of NHS reform, with the

Operating Framework for the NHS in England 2010/11 (Department of Health, 2009) developing policies intended to ensure a relentless focus on quality aiming to develop and deliver high quality and safe care. Understanding and applying management methods that will be beneficial for helping the NHS protect patients and improve the quality of patient care is therefore important (Baker, 2005).

Branine (2003), highlighted another NHS objective: increasing efficiency and value for money of service provision. In 2011, the National Quality Board published a report stating that as a result of changes in population demographics, the cost of medication and new technologies, efficiency savings of up to £20 billion is to be delivered by the NHS over 4 years. The aim is to improve quality of care and reduce costs by improving productivity and redesigning NHS services. Human performance experts have suggested that performance in a complex environment is influenced by both human and environmental factors (Ebright, Patterson, Chalko and Render, 2003). The challenge facing the NHS is attempting to manage the dual objectives of patient safety and quality improvement and efficiency savings, and this can be reflected in staffing.

3.3 Staffing in the NHS

The NHS, in common with hospitals in many other countries including the USA, Canada, New Zealand and Australia, is experiencing staff shortages, with a majority of the attention focussing upon a nursing shortage (Shields and Ward, 2001; Tailby, 2005; Massey, Esain and Wallis 2008). There have been attempts to identify causes of staff shortages, including problems with recruiting, retaining and motivating trainees and graduates (Pearson, Reilly and Robinson, 2004; Michie and West,

2004). Although outwardly this appears to be a redeemable problem, underlying factors including poor pay, expectations of the clinical workforce, increased intensity of work and poor working conditions provide continuing challenges (Michie and West, 2004; Finlayson, Dixon, Meadows and Blair 2002; Skinner, Riordan, Fraser, Buchanan and Goulston, 2006). In addition, the change in the demographic profile of the nursing population – with the profile of nursing ageing, the ability to implement policies and practices to encourage older nurses to stay in the workforce are important (Harris, Bennett, Davey and Ross, 2010).

Recent research by Loan-Clarke, Arnold, Coombs and Hartley (2010) explored factors leading to the retention, turnover and return of allied health professionals in the NHS. Reasons given in their longitudinal study for leaving the NHS included the perceived pressure of NHS work and issues with flexible employment conditions especially in relation to child care. Although the authors argued that provision of employment flexibility in the NHS has improved, allied health professionals perceived better flexibility outside the NHS. Arguments for leaving the NHS were formed around what was wrong with the NHS, rather than individuals being attracted to alternative employers. Those who remained, and to a lesser extent those who returned, did so primarily for economic reasons. Job security was perceived to be eroding as a result of resource constraints affecting both professional development and promotion opportunities, and the authors stated that the NHS needs to be aware of the potential impact of reduced development and career opportunities for staff.

Others have used the concept of the psychological contract in an attempt to explain why shortages in NHS staff have occurred (de Ruyter, Kirkpatrick, Hoque, Lonsdale and Malan, 2008). Their research reported that deterioration in job quality (as a result of government demands for greater efficiency resulting in rising levels of work

intensification, stress and declining morale) was a key factor in influencing decisions to opt out of permanent employment (and choose temporary contracts) in an attempt to minimise, if not completely avoid such pressures. Purvis and Cropley (2003) also discussed the nature of the psychological contract in relation to the nursing shortage. Nurses who perceived their expectations of personal recognition, being valued and supported and their status or rewards were not being fulfilled by the organization, and were consequently dissatisfied with their job and/or the organization were most likely to express their intention to leave. Ensuring employee commitment is a key concern in HRM because of its perceived association with job performance, but this has been under-theorised in nursing, even though work-life balance issues, access to preferred shift patterns (especially those which are family friendly) have been correlated to increased performance in nursing (Bennett, Davey and Harris, 2009).

Shortages in medical staff, of any level, can pose a potential threat to a patient's experience of care, and to the quality of care provided (Newman, Maylor and Chansarkar, 2001). Research from the USA into the implications of reduced nursing on wards concluded that patient mortality increased on wards with higher patient to nurse ratios (Aiken, Clarke, Sloane, Sochalski and Silber, 2002). A large-scale national survey of nurse staffing levels was conducted in the UK to determine whether the USA results were replicated in the NHS (Rafferty, Clarke, Coles, Ball, James, McKee and Aiken, 2007). Nurse and patient data from 30 NHS hospital trusts were analysed, with results replicating those from the USA; patients in the quartile where staffing levels were most favourable had better outcomes than hospitals with reduced staffing levels.

Indirect costs of staff shortages have also been recognised. Rafferty et al., (2007) examined the effects of hospital-wide staffing levels on nurse job dissatisfaction and

burnout. Hospitals with higher nurse staffing levels had significantly lower rates of nurse burnout and dissatisfaction. The authors concluded that as nurse burnout and dissatisfaction are precursors of nurse resignations (Sherward, Hunt, Hagen, Macleod and Ball, 2005), hospitals with favourable patient to staff ratios are more successful in retaining nurses. Workers who perceive higher levels of stress and job burnout have poorer coping responses (Lundstrom, Pugliese, Bartley, Cox and Guither, 2002), and if nurses are dissatisfied, this predicts their intention to leave (Jalonen, Virtanen, Vahtera, Elovainio and Kivimaki, 2006), potentially worsening the staff shortage (Bourbonniere, Feng, Intrator, Angelelli, Mor and Zinn, 2006). Nolan, Nolan and Grant (1995) after conducting a survey with nurses, midwives and health visitors about aspects of the work environment and overall satisfaction and morale, reported that feelings of being valued had decreased, as had satisfaction with pay and overall working conditions. Most practitioners in healthcare settings would agree that the relationship between the patient and provider is a key component of the overall quality of care and if this is diminished then patients could experience a reduced level of quality and satisfaction with the service (Garman, Corrigan and Morris, 2002).

In summary, having appropriate levels of staffing in healthcare is important if policies to maintain or improve patient safety and service quality are to be met. Shortages in healthcare staff (of which nursing is most commonly researched) have been reported to negatively affect patient care (Aiken et al., 2002; Needleman, Buerhaus, Mattke, Stewart and Zelevinsky, 2002), through reduced patient surveillance and less favourable recovery outcomes. Indirect costs of staff shortages, (increased pressure and decreased work satisfaction in permanent staff) (Rafferty et al., 2007) must also be monitored, especially if these behaviours result in staff

burnout and a higher intention to leave. Harris et al., (2010) noted that sustaining a nursing workforce is very difficult, and the decision to remain in the organization can be influenced by personal, professional and organizational factors. In an attempt to maintain suitable staffing levels, healthcare services may use temporary staff, the consequences of which will be discussed in the following section.

3.4 The Use of Temporary Staff in the NHS

The NHS has a statutory obligation to provide healthcare services to the public. To achieve this, wards need to be staffed on a continuous basis (Purcell, et al., 2004). Evidence regarding the consequences of reduced staffing for patient safety and service quality, partnered with increasing demands for hospital services, indicate the need to fill staff shortages.

When patient demand outweighs staff supply, the NHS becomes increasingly dependent on temporary staff (Hurst and Smith, 2011; de Ruyter et al., 2008; de Ruyter, 2007). Temporary staff are used to cover staff absences (illness, maternity leave), match short-term peaks in workload and provide staff flexibility, staff shortages and vacancies (Manias, Aitken, Peerson, Parker and Wong, 2003; Dziuba-Ellis, 2006; FitzGerald, McMillan and Maguire, 2007) to ensure adequate staff to patient ratios for the provision of safe and efficient care (Hass, et al., 2006). Creegan, Duffield and Forrester (2003), studied the ‘casualisation’ of the nursing workforce in Australia. Additional factors for the increase in temporary nursing staff were identified, including the nursing workforce being predominantly female, ageing and retiring, or wanting to work fewer hours.

Attempting to determine the true extent of temporary staff use, and whether there has been an overall increase in its use has been difficult. The National Audit Office's report (2006), "Improving the use of temporary nursing staff in NHS acute and foundation trusts" noted that, *"Although the Department collects some data on temporary staff, for example on expenditure on agency nursing staff, it does not have sufficient data to fully understand the extent and costs of using temporary nursing staff"* (page 2). The report states that although expenditure for agency nursing has reduced (indicating a reduction in agency temporary staff), this could have been as a result of a greater use of nursing banks or NHS Professionals as alternatives to agencies - one form of temporary staff being replaced by another. However in a NHS Employers Briefing (2010), four years after the National Audit Office's document, there were still reported difficulties in drawing firm conclusions on the relative use of bank and agency staff in healthcare due to inconsistencies in how temporary staff are classified.

Audit Scotland (2010), when discussing the increase in demand for locum medical staff in Scottish hospitals noted the impact of the implementation of the 48 hour working week for junior doctors under the European Working Time Directive (EWTD). Junior doctors could have previously been used to cover temporary shortages internally, but under the directive have fewer working hours available. Hospitals that had experimented with the 48 hour week before its implementation provided the cautionary tale of there not being enough doctors to cover clinical procedures (Pounder, 2008), and reports published by the British Medical Association disclosed that four in ten junior doctors in the UK are working on understaffed rotas as hospitals struggle to cope with the full EWTD implementation (Munn, 2010). This could lead to an increased use of temporary staff as a rational

solution to rota adjustment. However, even before the EWTD, temporary staff were used to help reduce excessive overtime, and the consequent fatigue and potential effects on patient care this could have caused (Shaffer and Kobs, 1997).

Temporary staff use in the NHS has often focussed on the financial cost, with reports of temporary staff costs ranging from five to fifty-two percent of hospital nursing expenditure, with agency spend taking up a disproportionate amount (Hurst and Smith, 2011). The authors report that London hospitals use notably more temporary staff, usually explained by an increasingly mobile and casual workforce, creating higher vacancy rates. However, as will be discussed in the following section, the temporary workforce in the NHS is not homogenous, adding further research complications. With regards to locums, the Audit Commission (1999) reported that the cost of locum doctors in hospitals varied from three to twenty percent of medical spending.

3.5 The Classification of Temporary Staff in the NHS

Several different forms of NHS temporary staff can be identified, for example, bank staff, external agency staff, locums and on-call staff. Additionally, temporary staff are not restricted to ward levels, for example, paramedics and administrative and clerical staff are also hired on a temporary basis when necessary.

3.5.1 Bank Staff

Individuals employed through a staff bank can work solely for the bank or in combination with other employment in the NHS (staff who may be willing to take on

extra shifts when needed) (Audit Commission, 2001). A bank staff member can be called to work on different wards (dependent on their relevant skill set) at short notice, and are seen as an integral part of the service (Northcott, 2002).

National Health Service Professionals (NHSP) was established by the government to provide a national approach to managing and providing temporary staffing solutions to the NHS, with the initiative to strengthen and support the NHS workforce (National Clinical Assessment Service, 2006). NHSP was developed as an in-house temporary staffing service, to take over the running of hospital nursing banks, managing in-house temporary staffing centrally (House of Commons Committee of Public Accounts, 2007). However, NHSP can have different relationships with hospitals it works with, ranging from the occasional provision of temporary staff, to the full management of the staff bank.

NHSP aims to help hospitals secure better value for money and attempts to keep the cost of temporary staff under control by establishing national prices for different grades of nurses (Hoque, Kirkpatrick, De Ruyter and Lonsdale, 2008). NHS bodies who seek temporary staff can contact NHSP, who then attempt to source somebody who meet their requirements. NHSP aims to improve the quality of temporary staff, particularly nursing staff, by providing assurance about the employment and training status of the staff procured (Department of Health, 2006a). NHSP is the employer of the temporary staff who are registered with it for the duration of the assignment. Once the assignment is complete they are no longer the employer (National Clinical Assessment Service, 2006). Along with clinical patient staff cover, NHSP also provides temporary staff for clerical and administrative posts.

3.5.2 Agency Staff

Private sector agencies also provide temporary staff to the NHS (Tailby, 2005). Hospital staff who choose to work for an agency may gain employment exclusively through commercial agencies, or may use the agency to provide additional shifts (either in an NHS organization or a private healthcare provider) (Purcell et al., 2004). Concerns have been raised regarding hospital's use of agency staff, since they can be financially costly, as a result of high commission rates charged by the agency, which do not need to adhere to nationally determined pay rates (House of Commons Committee of Public Accounts, 2007). Hospitals are encouraged to use NHSP or their staff bank as the primary supplier of temporary staff as a consequence of agency costs (de Ruyter et al., 2008). However, when demands exceed what NHSP or the staff bank can provide, hospitals may use agency staff. However, agencies with which hospitals have agreed quality frameworks with should be the first point of call (Audit Commission, 2001). There has been a move to develop closer contractual relationships with NHS hospitals and the agency market (Hoque, et al., 2008), especially in areas where specific skills are required, and Hoque, et al., (2008) in their research into contractual relationships in the agency worker market concluded that on face value the agreements have reduced temporary agency spend, and shown greater compliance in quality measures. However, the authors also reported that when financial objectives take priority, it seemed unlikely that quality standards would be achieved.

3.5.3 Locum staff

Locum doctors are used when there are vacancies or shortages at the doctor and consultant staffing level (Audit Commission, 1999, Audit Scotland, 2010), to cover

planned gaps in staffing caused by vacancies, maternity and annual leave, or unplanned gaps caused by sickness or unexpected vacancies in substantive posts. As with nursing staff, both internal and agency employed locums are used (Audit Scotland, 2010). Swinburn (2002), when discussing temporary hospital staff in Australia stated locums are a category of the hospital workforce who have not been particularly discussed. Audit Scotland (2010) argued the lack of and the difficulties of researching locums is because the size of the locum population is unknown.

3.5.4 On-call Staff

On-call workers can also be used to temporarily cover roles. On-call employees were described by Bernhard-Oettel, Sverke and De Witte (2005) as those who fill short term vacancies for a limited number of hours or days. Vahle-Hinz, Bamberg, Dettmers, Keller and Friedrich (2010) stated on-call work is used to provide a 24 hour service, but the work is provided on-demand when the skill is needed, or they can have a regular contract and work on-call is additional to their fixed schedule. Those who work on-call may either remain on-call on organizational premises, or may be called in to work during their leisure time (Vahle-Hinz, et al., 2010). Nicol and Botterill (2004) stated that having on-call staff was especially useful in professions such as healthcare where 24 hour coverage for emergencies, and workload fluctuations are necessary.

3.5.5 Other Forms of ‘Temporary Staff’

Although not ‘temporarily’ employed in the traditional sense, qualifying doctors could be perceived as temporary staff as a result of rotating through departments and

placements. In this way, they share some of the characteristics of temporary staff in being less familiar with the context and the work to be undertaken.

In summary, it is important that distinctions between temporary staff in the NHS are made, especially whether they are from a 'bank' or an external agency. Anecdotal evidence suggests that if temporary staff are recruited from the local bank they may have better relationships with the staff manager (Creegan, Duffield and Forrester, 2003), and if they are internal to the organization they will have some knowledge of the organizational structures and policies even though they may be assigned to a different ward (Page, 2008). However, distinctions between staff can go further than this. A temporary worker can be a permanent full-time post holder in the hospital who can work occasional extra shifts through the local bank. Similarly, part-time hospital staff can work through the local bank and when doing so will be classed as temporary. Some staff may solely work for the local bank; however, others may work in another hospital, or hold another temporary job. Similar distinctions can be made for those who work in temporary agencies that the NHS may use. As a result of the diverse nature of temporary employment in the NHS, it makes it near impossible to identify the number of temporary staff employed, however, it should be possible to calculate the number of shifts covered, hours worked and temporary employment costs.

3.6 Temporary Staff in Healthcare: Consequences for Patient Safety and Service Quality

The roles temporary staff undertake in healthcare settings can vary little from those of permanent workers, in that they usually share the same duties (Rotenberg, Griep, Fischer, Fonseca and Landsbergis, 2009). As a result they have been described as becoming central to the running of hospitals (de Ruyter, 2004). FitzGerald et al., (2007) argued that healthcare temporary staff may play a more significant and central role in quality and service delivery in comparison to temporary workers in other sectors as they carry added responsibility of having to maintain professional standards and have the responsibility of ensuring they have the skills and knowledge required for the role to maintain patient safety standards. They may also have to perform in highly stressful and complicated work situations (FitzGerald et al, 2007; Batch, Barnard and Windsor, 2009).

The Department of Health (2002) developed a code of practice for the use of temporary staff to ensure consistency and facilitate good practice among those who provide or use temporary staff in healthcare. However, evidence has accumulated suggesting that temporary staff could negatively affect patient safety and service quality, and relevant management practices could reduce the risks associated with their use. The following sub-sections each identify factors that could have implications for patient safety and service quality when using temporary staff.

3.6.1 Experience of temporary staff in healthcare

There have been debates about whether temporary staff have relevant experience, as it has been argued that experience influences patient care through clinical decision making (Hughes and Marcantonio, 1991). Experience includes understanding situations and teaches what typical events to expect in given situations and the modification of plans in response to these events (Benner, 1982). If a member of staff encounters different situations through temporary placements, they have had the opportunity to experience new scenarios and develop skills. Through experiencing differing placements, temporary staff may understand the demand of situations more clearly and act appropriately. However, when faced with new situations, temporary staff will have little understanding of the culture in which they are to perform tasks, and may need to be taught how to use equipment and the relevant staff protocols for providing safe patient care (Audit Commission, 2001; Castledine, 1997). Temporary employees who return to the same ward on a regular basis have the opportunity to experience real situations in familiar surroundings, having the opportunity to develop in-depth knowledge and expertise in a particular ward.

However, it is important not to view temporary staff as a homogenous group. In an on-line survey of nurses, Ball and Pike (2006) revealed that over half of those in temporary nursing positions undertook these roles even though they have a full-time permanent position. Of these, 87 percent were employed in the NHS (either in a hospital, GP practice or community setting), implying that if temporary staff are already working at a hospital/ward where such skills are utilised, they will have the necessary skills (provided they are placed on wards matching their skills). Those potentially having limited experience are those who work solely for agencies or banks, as this may not provide adequate opportunities for skill consolidation

(Manias, et al., 2003), although this may be dependent on the frequency and length of placements. Creegan et al., (2003) argued that when using agency staff, ward managers are dependent upon the agency to ensure staff with the relevant skills and experience are supplied, however, FitzGerald and Bonner (2007) claimed that agencies may make little attempt to match skills when allocating positions. Consequently experience levels of temporary staff are variable (Skinner, et al., 2006).

The experience of staff leads to the consideration of skill specialisation. Castledine (1997) reported a case of an agency nurse being put before a professional misconduct committee after a mistake had been made. The main contributing factor to the poor standard of nursing was not individual skill, but the lack of skills and experience related to work on that particular ward. If a temporary member of staff is placed on a ward where they do not feel confident to practice in, or have no experience in, this raises patient safety concerns (McHugh, 1997).

Aiken, Xue, Clarke and Sloane (2007) indicated that temporary hospital staff, particularly nurses, were no less qualified or experienced than their permanent counterparts, and there was little empirical evidence that using temporary staff has adverse consequences for patient outcomes. They suggested that the small number of studies that had reported an association between temporary staff and adverse events in healthcare had failed to take into account other factors that could affect outcomes when using temporary staff including: being poorly inducted to the ward and hospital procedures; inadequate briefings about their assigned patients and the number of resources allocated to a hospital or ward. Temporary staff may have the ability to undertake roles asked of them, however, problems associated with their use

could result from factors such as being placed in a hospital where staffing and the adequacy of other resources are poor (Aiken et al., 2007).

It therefore follows that when temporary staff are needed, those who manage them must ensure that temporary staff with relevant experience are employed. If this does not occur, local management will have to consider what alternatives are put in place to ensure that risks to patient safety and service quality associated with limited situational experience are minimised.

3.6.2 Knowledge of the physical environment and the role of induction

The environment temporary employees find themselves in could affect their performance, and consequently patient safety and service quality. Krogstad, Hofoss and Hjortdhal (2002) noted, “*Without knowing people and equipment, where to go, whom to ask...even expert observers may be unable to implement what they know to be the right course of action*” (p.37-38). The Audit Commission’s report (2001) focussed on maximising the potential of temporary staff, noted that any member of staff, however qualified, is unlikely to perform their best in an unfamiliar setting. Temporary staff’s time is wasted asking where things are and adjusting to the subtle differences and nuances between wards (FitzGerald and Bonner, 2007). Jones (1998), described the personal perceptions of an agency nurse, stating that until he was acquainted with the department, specific procedures and layout, he was most comfortable undertaking simple task-orientated work (e.g. basic observations). Having experienced working in new environments and understanding the implications of asking permanent staff for explanations of tasks or roles, Jones (1998) recommended that for managers: “*The easiest plan is to encourage the same*

agency nurses to return to the department, thus saving the daily grind of explanations and frustrations” (page 52). Differences in technological equipment have also been considered as a factor influencing patient care (Huckman and Pisano, 2006, Cushing, 1983). In a study based on in-depth interviews with full-time agency nurses Hass, Coyer and Theobald (2006) reported that agency staff felt more confident having knowledge of the technological equipment and subsequently this led to increased confidence in their ability to undertake patient care.

Huckman and Pisano (2006) studied the importance of hospital specificity and individual performance in cardiac surgery. They explored the premise that performance could be portable across different organizations (in this case, hospitals), but it could vary if organization-specific skills and knowledge can only be developed over time. They concluded that the longer a surgeon spent on a ward or in a particular hospital (and as a result gaining a greater understanding of the specific environment), this correlated with a lower risk of patient mortality. When highly skilled workers have to interact with a complex array of factors, performance may not be easily transferred across environments (some portion of the performance is organization-specific), regardless of their ability.

Limited knowledge of the physical working environment can be largely rectified by induction. The ‘Code of Practice for the Supply of Temporary Staffing’ (Department of Health, 2002) states providers should ensure induction is in place for all staff, noting that this could improve the effectiveness of temporary staff. Induction should include appropriate information regarding policies and procedures used in the specific hospital environment. The Audit Commission (2001) believed induction was key to reducing lack of familiarity, and if undertaken effectively could lead to situations where temporary staff would rely less on ward staff and improve

the quality of patient care. Although hospitals had induction programmes only 40 percent of staff recruited on bank-only contracts could recall attending an induction and most of those who attended an induction reported its quality as unsatisfactory and in some places irresponsible (Audit Commission, 2001). As there was no degree of consistency with inductions, hospitals could not be confident that all staff were operating within relevant practices and protocols.

Audit Scotland's (2010) report on the use of locum doctors found that very few NHS trusts had formal induction policies for them (this had been highlighted as an issue 12 years previously). A survey of a small number of locum doctors in the report highlighted differences in the quality of inductions, indicating locums covering short term gaps received inductions less frequently and the information provided was basic, compared with longer-term locum posts where only 12 percent rated the induction as poor. The role of induction is therefore an important element in research on temporary staff and patient safety.

3.6.3 Training and professional development

Training and professional development may be reduced for temporary staff due to the high costs involved and limited tenure of the temporary employee (Wiens-Tuers and Hill, 2002). Questions have arisen regarding the lack of training for temporary staff, and the implications for patient safety and service quality, often in relation to cost-effectiveness, and the NHS achieving value for money (de Ruyter, 2007, Department of Health, 2006a).

The Audit Commission's (2001) report, noted that hospitals must ensure appropriate systems are in place to verify the qualifications of temporary staff, and provide

access to any training and development needed. It reported that bank staff were less likely than permanent staff to attend mandatory training events. In the Audit Commission's (2001) survey of bank staff, less than two in five bank-only nursing staff had updated their basic life support training and just under half attended moving and handling training. However, the problem was thought to be worse for those who work solely through private agencies as training would have to be arranged by the individual, meaning taking time out of paid work, increasing the risk that mandatory training may not be kept up to date (de Ruyter, 2007). Audit Scotland's (2010) report on medical locums stated that pre-employment checks, especially for agency locums were not always formalised, thus it was not always clear whether registration with medical councils, training and occupational health certificates were up to date.

In a report in response to the Audit Commission's (2001) document, the National Audit Office (2006) aimed to derive a national and hospital level understanding of how hospitals determine temporary nursing staff demand, procurement and the impact of initiatives to improve quality. The report noted that quality assurance procedures within the NHS were not standardised, and despite the Code of Practice for the supply of temporary staffing (Department of Health, 2002) results indicated that less than 70 percent of bank nurses received mandatory training in the 12 months prior to September 2005. Thus there had been limited improvement in the training of temporary staff, despite framework agreements maintaining that temporary staff are to receive mandatory training (National Audit Office, 2006). With limited training available, or accessible, this could undermine patient safety care procedures. Ball and Pike's (2006) on-line survey examining the views and experiences of nurses, reported that the career development of bank and agency nurses could be affected given limited access to training and professional

development, with 32 percent of bank and agency nurses indicating they did not have access to professional development (the authors did not report separate bank or agency percentages). Audit Scotland (2010) reported upon local supervision and performance management for locum doctors, and neither were particularly well developed. Junior doctor locums were generally supervised by the lead consultant, and locum doctors at consultant grade may not have been supervised if a senior colleague was not available.

With regards to feedback and performance assessment, Audit Scotland (2010) reported that few NHS boards had corporate policies relating to the performance management of locums, and feedback was primarily verbal. The report added that little had changed since the previous audit in 1998, despite calls being made to hospitals to monitor the skills, knowledge and professional development of temporary staff, and for greater investment to support professional practice (Wright, 2005, FitzGerald and Bonner, 2007).

Benn, Koutantji, Wallace, Spurgeon, Rejman, Healey and Vincent (2009) when discussing feedback stated that effective feedback from incident reporting systems in healthcare is essential if organizations are to learn from any failures. The National Audit Office's (2005) "A safer place for patients: learning to improve patient safety", reported little consistency of feeding back issues of best practice across hospitals. West, Borrill, Dawson et al., (2002) stated that the purpose of appraisals and feedback was to direct employee performance towards achieving organizational goals and to improve individual performance, and in their research demonstrated strong links between HR practices such as training and appraisal systems and patient mortality in hospitals. If temporary staff are not included in feedback programmes, or have little opportunity for professional development, this could lead to greater

patient safety risks. Moss and Paice (2001) reported that medical trainees on rotation had little opportunity to develop organizational loyalty or engagement with those in a department, making feedback difficult, yet they had front-line staffing responsibilities.

With variations in training levels and feedback practices among different temporary staff, this suggests that certain temporary staff could provide a greater risk to patient safety. As previously discussed, there are many forms of temporary staff in the NHS, and depending on the frequency of the temporary shifts, whether the temporary employee is a permanent full-time post holder or covers temporary shifts temporarily, and whether the temporary cover is sourced from the local bank or from an agency can all affect the level of training they receive or have access to, consequently influencing patient safety and service quality. If temporary employees are not told of development opportunities, questions can be raised as to who is at fault if a patient incident occurs.

3.6.4 Knowledge of the human environment and team work

Lundstrom, et al., (2002) indicated the importance of organizational factors in patient safety; sharing knowledge, team work and common goals are all important for reducing the occurrence of adverse events. Having an understanding of the team in which you are placed is key (Huckman and Pisano, 2006). FitzGerald and Bonner (2007) believed that it was important for a team to support temporary staff starting a shift, for example, being more willing to convey necessary information. If permanent staff impart necessary knowledge for daily practice, this will lead to increased efficiency. Communication with team members is essential to understand

how tasks are conducted on the ward, and integration into departmental life was considered to be vital for the cultivation of “shared ways of seeing” (Hughes, 1989, p. 403).

Finn and Waring (2006) argued that knowledge sharing is a key resource for organizational success, and elements of the NHS context have been shown to influence this. They argued that flexible staffing practices can have an effect on team stability and create situations where knowledge transition may be disrupted. This is particularly the case with what they term architectural knowledge (knowledge that is context specific and emerges over time). When disruption occurs this will affect organizational effectiveness and communication. A similar argument can be put forward with regards to social and intellectual capital (Hoque and Kirkpatrick, 2008), when temporary workers may not have the organization-specific knowledge to function effectively. Based on the assumption that networks of relationships constitute a valuable resource, social capital could increase efficiency of action, influencing the development of intellectual capital, leading to superior performances (Nahapiet and Ghoshal, 1998). However, as time plays an important role in the development of social capital, stability and continuity of the social structure were thought to be key, as the duration of stability of social relations influence the clarity and visibility of mutual obligations (Nahapiet and Ghoshal, 1998). The use of temporary staff on a ward may affect the development of social and intellectual capital in a team, as they may not have the opportunity to integrate themselves. Adams and Bond (2003b) explored the relationship between staff stability and features of a ward organizational environment. The authors found that the use of bank and agency nurses was correlated with low cohesion scores, and this was supported through the use of staff interviews which reported that the use of bank and

agency nurses was associated with the degree of cohesion nurses experienced with their peers. In the same study, wards with higher usage of bank and agency staff perceived standards to be lower, with nurses more likely to report an inability to cope. Adams and Bond (2003a) concluded that if greater staff stability can be achieved, nurses will have opportunities to develop practice and patients would be more likely to benefit from better quality care.

Hospitals are fast moving and constantly changing environments. This turbulence can impede the capacity to provide high quality care, especially when features of effective organizations, such as organizational communication, shared goals and effective problem solving are interrupted (Ramanujam and Rousseau, 2006). A systems approach provides an opportunity to maximise organizational learning with the potential to improve performance (Slater and Narver, 1995). Organizational learning involves learning by members of the organization, and a set of organizational learning mechanisms promoting collective action on the basis of this learning (Sheaff and Pilgrim, 2006). Organizations learn through their members (Lipshitz and Popper, 2000) and build upon past knowledge that can be retained and deployed throughout the organization (Nutley and Davis, 2001). Learning is then encoded into routines.

The learning organization was described by Senge (1990) who described 'five disciplines' or ideal features to attain best practice: *personal mastery* (employees becoming committed to their area of work), *mental models* (deeply ingrained assumptions and generalisations that influence how an individual views the world and behaves), *building a shared vision* (creating a unifying purpose in an organization, and shared pictures need gaining genuine commitment), *team learning* (a genuine dialogue between team members to discover insights that would not have

been attainable individually), *systems thinking* (each part of the system has an effect on another part, and this can only be understood when you look at the whole picture, and not solely at individual parts). An organization can learn to continually expand its capacity to generate new ideas and adapt to survive. Sheaff and Pilgrim (2006) used these features to explore the climate of the NHS to ascertain if the principles of the learning organization could be implemented. They concluded that the complexity of the NHS meant organizational learning was not as effective as it could be due to the constraints on being able to learn from mistakes.

The National Audit Office (2005), reported that a strategy for learning at a national level in UK hospitals has been slow to develop and effective communication is essential to reducing unintended patient incidents. If organizations develop shared meanings and actions, a common language and social interactions will evolve. Sharing information means ideas and learning may be preserved in an organization's memory (Walsh and Ungson, 1991). An organizations retrieval of this memory will affect any decisions made.

Argyris (1977) indentified two forms of learning: single loop learning (error is detected and corrected, but the process is left unchanged) and double loop learning (norms, policies, procedures and structures are questioned and then reformed, challenging an organization's memory and learning). Knowledge sharing among individuals and team work is key (Specht, Chevreau and Denis-Rémis, 2006). Pressures on the healthcare system can impede such re-thinks and as a result radical change fails to materialise, unless there has been a crisis (Davies and Nutley, 2000). Learning from others includes the provision of continuing education and developing new insights with the potential to influence an individual's behaviour. It has been

argued that a learning environment where individuals can challenge decisions is needed (Slater and Narver, 1995; Edmondson, 2004).

Temporary staff might affect organizational learning in a number of ways. If open communication is encouraged, using temporary staff can have implications for changing team dynamics by reducing trust, which is gained over time through social interactions (Koster and Sanders, 2007). As learning about the behaviour of co-workers can affect co-operation, if a temporary employee is only on a particular ward for one shift, this provides limited opportunity for trust and co-operative relationships to develop. Organizations must be aware of this and its implications for communication (Koster and Sanders, 2007). Group membership identification has the potential to affect communication between groups, inhibiting the transfer of knowledge. This communication between groups can also be associated with the willingness to report errors and learn from them (Edmondson, 1996).

If organizational learning is to be successful, then communication of information to temporary staff regarding organizational practices is important. Leonard, Graham and Bonacum (2004) and Firth-Cozens (2001) reported that effective communication and teamwork is essential for the delivery of high quality, safe patient care and that communication failures are an extremely common cause of patient harm. Tsang (1997) argued organizational learning would only lead to better performance if the knowledge obtained and acted on is accurate. However, if double loop learning has a greater impact on changing processes and structures, this leads to questions about whether temporary staff have the social cohesion and shared attitudes to produce behaviours directed to organizational goals. If temporary employees perceive little group cohesion, they may see no reason to conform to group norms. Alternatively,

they may feel unable to confidently communicate information due to lack of team familiarity.

3.6.5 Continuity of care

Daubener (2001), when commenting on temporary staffing within nursing quoted senior hospital staff saying, “*Continuity of care is difficult to maintain when temporary staff provide patient care*” (page 509) as staff constantly change, meaning that tasks may not be completed. Haggerty, Reid, Freeman, Starfield, Adair and McKendry (2003) identified different forms of continuity of care in relation to patient care: informational continuity (a common thread linking providers, including both medical and personal information); management continuity (especially important if the patient requires management from a variety of providers) and relational continuity (a consistent core of staff providing patients with a sense of predictability). Krogstad, Hofoss and Hjortdahl (2002), in a reflective paper based upon theory and experience of hospital work argued that continuity of care is important for patient satisfaction, both ‘front stage’ continuity, where the patient sees the same staff day after day, and ‘back stage’ continuity, where all staff know patient plans and where information received is consistent. Blumenthal (1996) discussed the importance of ‘front-stage’ continuity, stating that the quality of care and quality of interaction between the physician and patient is developed through the quality of communication and ability to maintain trust. If there are gaps in care (seen when there are changes in authority or professional roles) these commonly appear as loss of information or interruptions in the delivery of care (Cook, Render and Woods, 2000).

Continuity of patient care was reported to have increased patient satisfaction in general practice settings (Hjortdahl and Laerum, 1992). Johansson, Oléni and Fridlund (2002) in their literature analysis of care provided by nurses, reported the importance of receiving adequate information, facilitated by being cared for by familiar staff. As patient satisfaction is a quality indicator, maintaining this continuity of information seems key to service quality. The importance of informational continuity was discussed by Patterson, Roth, Woods, Chow and Gomes (2004) when handing over information, and the necessity for accurate information to meet quality and safety goals.

Continuity of care has been linked to the level of team integration experienced by temporary staff (Krogstad et al., 2004). Dependent on the length of the temporary placement, there is a limited likelihood that a temporary worker would be on the same ward the next day, and thus questions should be asked about how to best manage service quality when temporary staff are used. Krogstad et al., (2004) argued a common ethos of continuous or collective learning is to be cultivated to ensure that information necessary for patient care is transferred.

3.6.6 Regulation of working hours

Fatigue has long been known to affect safety in other industries (e.g. aviation) (Wright, 2007), but physicians have also acknowledged the impact of fatigue on patient care. Monitoring hours or number of shifts worked in a week needs to be undertaken when hiring temporary staff, especially if extra shifts are being sought in addition to substantive posts. Ball and Pike (2006) conducted an online survey to examine the experiences and views of bank and agency nurses from Royal College

of Nursing members. The survey received 530 completed responses, and the researchers found that 55 percent of the respondents reported taking on bank/agency shifts on a regular basis (on average respondents undertook 5 bank/agency shifts a month). Substantive staff working additional hours were more likely to say they found the additional work exhausting and stressful (13 percent, compared to less than one percent of nurses working bank/agency only), indicating staff working excessive hours. Studies undertaken to determine the relationship between fatigue and frequency of errors in hospitals, indicated increased error rates over extended working periods. For example, Rogers, Hwang, Scott, Aiken and Dinges (2004) found that risks of errors in patient care were significantly increased when individual shifts were longer than twelve hours, when nurses worked overtime, or when they had worked over 40 hours a week. Lloyd (2005) when discussing the impact of the European Working Time Directive (EWTd) reported objective evidence regarding the deleterious effects of sleep, including research reporting that the speed and accuracy tests in anaesthetists and surgical trainees were significantly impaired after having spent a night on-call.

Although increased working hours are not only applicable to temporary staff (Tailby, 2005), the issue lies with the hospitals ability to monitor hours worked, and whether measures are in place for regulating working hours and ensuring that adequate checks are undertaken when temporary workers are hired. This is now of heightened importance with the full implementation of the 48 hour working week, under the stipulations of the EWTd. Peerson, et al., (2002) raised concerns regarding work-time regulations when using agency staff in particular, as different agencies had varying rest requirements. In a UK report, none of the hospitals visited had robust systems for monitoring the number of hours worked by their nursing staff (House of

Commons Committee of Public Accounts, 2007). The Audit Scotland (2010) report showed little progression in this matter in Scottish NHS hospitals, especially with regards to the EWTd. There were records to show substantive staff complying with the terms, however there were no processes in place to check hours worked by locum doctors. This was due to the difficulties in tracking locums, who may work in a number of different locations during a week. The report mentions the reliance on self-regulation by locums; however, there was no evidence provided to suggest this was a sufficient measure of compliance to the terms of the EWTd. The regulation of hours worked by locums is clearly an issue that needs to be considered and questions remain regarding whose responsibility it is to check the working hours of the temporary employees, and what processes are put in place if somebody has worked too many.

3.6.7 Impact on Permanent Staff

The themes discussed have indicated how temporary staff in healthcare could directly affect patient safety. However, some research suggests temporary staff could affect other aspects of the hospital system – with attention focussing upon their impact on permanent employees. Pearce (1993), found that using temporary staff resulted in distrust in the organization among permanent workers, who expressed this behaviourally with reduced performance and an increased intention to leave. Research has been conducted to see if similar effects have been found in hospital environments. Hayes, et al., (2006) reported that turnover in nursing staff can decrease the morale of those left on the ward, resulting in reduced productivity. Permanent nurses perceived themselves to be under increased stress (Adams and

Bond, 2003b), reducing effectiveness and efficiency, consequently affecting patient safety and service quality (Newman, Maylor and Chansarkar, 2001).

Using temporary staff on a ward could, paradoxically, increase the workload of permanent staff. Hoque and Kirkpatrick (2008) reported that permanent staff felt under constant demand to socialise and train new staff members. When ward orientation was provided by a permanent member of staff, there was seldom an adjustment in work allocation to compensate for time taken away from official duties; tasks were delegated to others creating, *“Pressure of a different kind and quite possibly resentment”* (FitzGerald and Bonner, 2007, page 654). Similarly, if the temporary worker did not have the necessary skills, the lack of ward-specific knowledge could lead to inequitable divisions of tasks, resulting in permanent staff undertaking the tasks the temporary staff were unable to perform (Hass, Coyer and Theobald, 2006; Hoque and Kirkpatrick, 2008). This could be a potential source of disharmony, and serve to reinforce underlying stereotyped perceptions of temporary staff (Batch, Barnard and Windsor, 2009). Dissatisfaction in the work environment as a result of increased workloads could lead to diminished quality of care, and further costs to the organization can occur if dissatisfied permanent staff leave the organization (Batch et al., 2009). This could worsen patient safety as ward staff levels would be further reduced. Audit Scotland (2010) reported that when no locum doctors could be procured, other doctors within the team had to cover their workload and senior staff had to cover the workload of junior doctors to avoid service reductions. If permanent staff do have to take on extra responsibilities, and often without added compensation (Davis-Blake et al., 2003), this could be perceived as a breach of their psychological contract. Management therefore needs to be aware of the impact of temporary staff on permanent staff.

In addition to taking on extra responsibilities to induct temporary staff and supervise their work, senior staff may have to take time away from patient care to locate the additional staff needed for cover (Manias et al., 2003). The Audit Commission's (2001) report stated that where there was a centrally co-ordinated staff bank the average time for co-ordinating temporary cover was 9 minutes, compared to half an hour where there was no central bank. In the later case, there were instances where lists of hospital banks/agencies that could be used to source temporary staff were out of date, adding to mounting pressures on team leaders trying to rectify staff shortfalls. Interventions to reduce booking times would not only save staff costs, but release extra time for patient care. The Audit Commission (2001) recommended the use of IT to improve temporary staff booking administration however, the National Audit Office (2006) found that very few hospitals used electronic rostering, even though this would help ward managers.

Although some permanent staff realised that without temporary staff they would have difficulty running wards (Tailby, 2005), resentment between temporary and permanent staff also occurred as a result of the hourly pay differences for doing the same job (Swinburn, 2002). Hoque and Kirkpatrick (2008) discussed that work place relationships could be affected as agency workers earn more (in terms of direct pay) than permanent employees, and this was a source of resentment, and managers commented that permanent employees were deciding to work through agencies to benefit from this added income.

3.6.8 System Impacts

There has been a tendency to blame patient facing staff for errors that could affect patient safety and service quality (Anderson and Webster, 2001, Reason, 2000). Human factors are commonly blamed as they are most readily identifiable prior to the error occurring (Department of Health, 2000b). However, Vincent (1997) proposed the use of systems thinking when discussing the underlying causes of errors; looking carefully at, and conducting examinations of care provided to patients to identify all the weaknesses that could be present (Battles and Lilford, 2003). Tamuz and Thomas (2006) also argued that to improve patient safety, it is essential to understand how the organizational environment influences hospitals' efforts to identify and learn from medical errors.

The premise of the systems approach is that all humans are fallible, and even when working in the best organizations, mistakes will be made. However, errors can occur as a result of the systemic failures (Reason, 2000), including an organization's strategy, culture and approach to risk management. A distinction should be made between active and latent errors (Institute of Medicine, 1999; Lawton and Parker, 2002; Reason, 2000, 2001). Active errors in healthcare are unsafe acts committed by those who are patient facing and can have immediate adverse consequences. Latent errors occur as the result of decisions made at higher organizational levels and may only become evident when combined with a local triggering factor (Reason, 2001). There is a common assumption that using temporary staff could be of increased risk to patient safety, with the potential to make more errors as a result of reduced experience in new surroundings. Using systems thinking, other factors (for example, speed of staff replacement, induction, limited support from other staff) could play a role.

Clarke (2004) argued that a positive safety culture and an open climate are necessary for sharing information, and developing a shared responsibility to improve safety. The National Patient Safety Agency (2004) published seven steps to patient safety, understanding that the complexity in healthcare systems can lead to risks. Building a safety culture was the first of these steps, encouraging a culture where individuals speak up about any incident and encouraging all individuals to be safety conscious. The safety culture also takes into account all conditions leading to specific actions which will help with learning lessons and changing practice. Edmondson (1999) studied the role of psychological safety in work teams, concluding that shared beliefs about other's actions will develop over time, and team structures shape team outcomes, with Naevestad (2008) adding the single most important factor in creating a good process safety culture is trust, creating an environment where safety critical information can be shared among employees. Temporary staff use could impede the development of a safety culture as communication based on mutual trust and shared perceptions of the importance of safety may be limited (Clarke, 2003). West (2001) reported that there were limited studies looking at management of culture and the quality of patient care, and criticised the lack of attention to culture as an important influence in managerial decision making, and argued that employees (of any kind) cannot make good decisions without sufficient information and training, and they would be unlikely to make suggestions if there is not a safety culture and they feel this will cost them their role. The role of temporary workers and their management when discussing the safety culture has been under-researched.

3.7 On-Call Staff in Healthcare

On-call workers have been defined as employees of an organization who are called upon to work as and when needed to cover specific tasks or roles (Houseman, 2001). On-call employment is a distinctive feature in some occupational contexts (utility workers, IT, media personnel), but in healthcare it is of particular importance as it allows for flexibility in staff to meet local needs and ensure patient care provision 24 hours a day where emergencies require personnel to deal with critical situations immediately, and where the volume of work may not necessitate a full shift coverage (Nicol and Botterill, 2004). On-call work has been described as more precarious than other forms of temporary employment (Bernhard-Oettel, De Cuyper, Berntson and Isaksson, 2008) because stressors can be exacerbated in terms of higher uncertainty in employment and very limited inclusion at the workplace. Thus, the management of on-call workers is of importance if such stressors can affect organizational outcomes. However, studies about on-call workers are scarce, particularly when related to organizational attitudes (Bernhard-Oettel, et al., 2008).

Nicol and Botterill (2004) reviewed the limited literature related to on-call work patterns and health. The review indicated that the implementation of on-call schedules can differ in terms of the nature of on-call, the hours designated to be on-call and the affect on social circumstances; for example, for many occupations, working on call means being called back to the work environment as and when necessary. This may lead to restrictions on the location and type of leisure activities conducted when participating in the on-call rota. For others, especially junior doctors or other residents in medical training, those on-call may be resident in their organization for the on-call period, with sleeping facilities provided. This is a distinctive form of on-call, because workers remain at work to undertake their on-

call duty. In some occupations (e.g., pilots), on-call hours are reduced with seniority. For many professions, on-call scheduling is a normal component of the occupation, and can include periods of interruption to either sleep or family and social life, and often includes a level of uncertainty about whether and when a call will come.

The effects on individuals who work on-call patterns have been identified. Smithers (1995) when researching on-call transplant co-ordinators found that fatigue and reduction in work performance were the main effects of on-call, with sleep difficulties, meal regularity and the quality of off-call time having a potential for compromised health. Lindfors, Nurmi, Meretoja, Luukkonen, Viljanen, Leino and Härmä (2006) found similar results among on-call anaesthetists, who also reported difficulties in combining work and family relationships. However, on-call work cannot be abolished, as service quality through service provision has to be assured (Lindfors, Heponiemi, Meretoja, Leino and Elovainio, 2009). Consequently it is important to investigate the effects of on-call work for patient safety, and how this can be best minimised.

When discussing patient safety and medical error incidences, the Institute of Medicine highlighted the major contribution of lack of, or inadequate sleep of healthcare providers (Landrigan, 2005). Lack of, or poor quality of sleep as a result of working on-call has been recognised in the literature. Torsvall and Akerstedt (1988), although not studying a healthcare population, found that during nights on-call, workers slept an average of 1.5 hours less per night. This was not just as a result of being called-out, but the resulting apprehension of being called to work. This apprehension served as a stressor and was seen to interfere with normal sleep patterns. Nicol and Botterill (2004) also reported sleep interruption, especially in

professions that deal with emergencies that can occur at all hours. They noted the apprehension about being called at any time negatively affecting sleep quality. Cropley and Purvis (2003) investigated the inability to 'wind-down' and sleeping behaviours, concluding that those who had little control over the hours they worked (as can be the case with on-call work), found it increasingly difficult disengage from work activities, reporting high levels of stress and health problems.

Recent research conducted by Vahle-Hinz, Bamberg, Dettmers, Keller and Friedrich (2010) on the effects of on-call work on health outcomes in a predominantly male sample (30 men, 1 woman) of network administrators concluded that those working on-call had to adapt their leisure activities during the on-call period, regardless of whether they had to work or not. Being on-call was viewed as an interference to the individual's personal and social life, even if they were not called out. Those prone to anxiety or worrying tended to experience more work-related strain when on-call, and those who appraise on-call work negatively were more likely to report negative moods when on-call. The assumption that on-call work decreases health at a physiological/somatic level was not supported by this study. However, this could be explained by the low demands of on-call work experienced by the sample, the short period of time they had to work when on-call and having the necessary equipment provided to easily undertake the role the on-call work demanded. Additionally, the study only focussed upon the short-term effects of working on-call, providing no indication as to whether effects continue, improve or worsen with the duration of the on-call period.

Increased fatigue experienced by those working on-call can affect patient safety and service quality. Arnedt, Owens, Crouch, Stahl and Carskadon (2005) showed the performance deficits in paediatric residents who had been working a heavy on-call

rota (e.g. decrements in attention, vigilance, impairment and reaction times) were comparable to the effects of alcohol consumption. Those with less sleep after nights on call made 50 percent more attentional failures and 22 percent more serious errors on critical care units than when working on traditional schedules with reduced hours. French, McKinley and Hastings (2001) also reported the effects on service quality as a result of on-call fatigue, concluding that periods on-call resulted in raised GP stress (both in anticipation of being on-call, and as a result of the on-call hangover) compared to when not on-call. Patients seen by GPs in sessions before and after a night on-call were less satisfied than patients seen by GP's before or after a night off duty.

On-call shifts among anaesthetists were connected to high levels of stress as a result of unpredictable working hours, the potential limited opportunity for a full consultation with patients, and the difficulties of combining family time and working on-call (Lindfors et al., 2006). Common symptoms reported as a result of this increased stress included: irritation, feeling cold, memory disturbances and headaches. Respondents noted that the responsibility and fear of harming patients when on-call was a source of stress. Poor on-call working conditions have also been reported as a source of stress, dissatisfaction and low morale. Masterson, Ashcroft and Shah (1994) reported that trainee anaesthetists required to be resident on-call did not find their on-call accommodation to be of an acceptable standard, with poor access to catering facilities, and some questioning their personal safety if the accommodation provided was far away from their working area. Callaghan, Hanna, Brown and Vassilas (2005) conducted a study of the experiences and concerns of psychiatric senior house officer (SHO) on-call workers. Those interviewed described being asked to undertake inappropriate tasks including, referrals

(inappropriate referrals that should have been completed by others during conventional working hours), non-critical medical problems and administrative tasks (including the arrangement of patient transfers and finding beds). The survey recognised that out-of-hours on-call did enable the trainees to gain a broad range of experiences, in comparison to traditional working hours. However, there were concerns that being on-call could be isolating, and responses indicated that on-call workers did not feel integrated into a team – potentially adding to patient safety concerns.

As previously reported by Lundstrom et al., (2002) those who perceive higher levels of stress tend to report poorer coping responses, which could threaten the quality of patient care in healthcare settings. There were concerns regarding staff burnout with longer hours resulting in fatigue and stress for the individual, and the potential consequences this can have for patient safety. If on-call employment is necessary, how can it then be best managed to reduce potential patient safety and service quality risk?

In summary, on-call work provides a distinctive example of the flexible or non-standard working patterns that can be found in the NHS. Although usually used to cover a specific role, on-call work brings with it other complications, including the potential for fatigue, the stress associated with the unpredictable nature of working hours, and the impact on the individual's quality of life – all of which could affect patient safety and service quality if not managed appropriately.

3.8 Difficulties in Studying Temporary Staff in Healthcare

The literature discussed above describes how temporary staff are often relied upon in healthcare to ensure appropriate staffing levels to maintain service delivery and satisfactory patient safety and service quality. Ways in which patient safety and service quality could be at risk were identified, with the common assumption that care provided by temporary staff is poorer in comparison to permanent employees. However, as a result of the range of temporary staff used in healthcare, some research has questioned the strength of this common assumption. Hurst (2005) indicated that research discussing the relationship between temporary staff use and quality necessitates further enquiry.

Audit Scotland (2010) reported, *“It is not possible to establish whether locum doctors pose a greater clinical risk than their counterparts in substantive posts”* (page 25). The report states that 7 percent of General Medical Council investigations are related to locums with addresses in Scotland, but cannot compare this figure to substantive posts, as the size of the locum population is unknown. Additionally, incidents and complaints do not record whether or not the doctor was a locum at the time of the incident. Similar issues were raised in a report aiming to understand locum arrangements in the Australian district of New South Wales (GMCT Metropolitan Hospitals Locum Issues Group, 2005), noting that information about employment status is not collected at the time of the complaint, resulting in no clear evidence available to link the use of locums with increased patient harm or adverse clinical events. The report argues that there is anecdotal evidence of risks associated with temporary staff in hospitals, but there is insufficient evidence to reach firm conclusions. Statistical data regarding the use of locum medical practitioners is sparse. Medical locums are either not included in staff surveys, or they are defined

as medical practitioners according to the position they have filled, resulting in no clear differentiation between locums and regular employees.

Shann and Hassell (2006), argued that very little is known about the locum workforce, why individuals choose to become locums, and what consequences this may have for practice. As with temporary employment more generally, they argue that the heterogeneity of the locum workforce has to be taken into consideration, as outcomes for one group will not necessarily be true for all. Their study, involving in-depth interviews of locum pharmacists, illustrated that people chose to work as locums for many reasons, including: flexibility, time for other activities, choice of location, different needs and expectations of the work. Although, now a dated article, Hoyal (1998), felt there was a failure in the literature when discussing the assessment, evaluation and standards of locums, and believed that quality of locums should be assessed based on competencies such as knowledge, skills, attitudes and other indicators related to practicing within a hospital environment. With the perceived importance of locum use there should be some clarity in demonstrating the significant features predicting a 'good' locum, and the level of care provision (Hoyal, 1998).

In terms of temporary nursing, there is considerable blurring of definitions associated with temporary nursing practices, and there is flexibility in the roles they undertake (Richardson and Allen, 2001). This raises the issue of whether data collection is impeded by a lack of systematic definitions of the nature of temporary nursing in healthcare. Clarity in definitions and stating the type of temporary employee researched is needed, especially when discussing results in relation to patient care.

However, the literature above indicated that when discussing temporary employment, it is important to study the systems in which they are found (Aiken, et al., 2007). Other researchers have discussed the possibility of using a comparative approach for assessing competence in different nursing situations, in an attempt to understand contextual elements of nursing practices (Meretoja, Leino-Kilpi and Kaira, 2004). They argued that context specific knowledge is necessary to structure work environments adequately so that quality care is provided. It is also important to study the effect that temporary staff have on those who work alongside them, and Hass, et al., (2006) argued further qualitative research needs to be conducted with permanent workers to see what actual impact temporary staff have on their work practices. Thus, research into temporary staff in healthcare needs to recognise the system that temporary staff are found in, and the affect temporary staff can have on those they work alongside.

3.9 Conclusions

This chapter has reviewed literature regarding the management of temporary staff in healthcare. The NHS in the UK uses a variety of temporary staff, both internal to and external from the hospital and varying in length of time spent in the temporary position. Although initiatives such as staff banks and NHSP have been introduced in an attempt to improve patient safety, concerns are raised related to the use of temporary staff in the NHS, and the use of agency staff is still prevalent when demands for staffing are high. When discussing the impact of temporary staff on patient safety it is therefore important to consider the form of contract, as this may affect how they act, how they are managed and what is expected of them.

The literature has provided many examples indicating how temporary staff could be a risk to patient safety: limited familiarity with the environment (both human and physical), and the consequences this could have for local awareness of policy and procedures, especially if a local induction is not given. Professional development opportunities may be restricted to temporary staff, and issues such as continuity of care and monitoring the hours they work have all been identified as areas for potential risks. This highlights the importance of the management of temporary staff, so that patient safety and service quality levels are maintained when temporary staff are hired. Additionally, the role of the system and how those who temporary staff work alongside react to them can also influence how well temporary staff perform and patient safety outcomes.

Batch et al., (2009) and Houser (2003) both noted paradoxical issues regarding the use of temporary staff in healthcare – the need for temporary staff to ensure adequate staffing levels, but the common concerns and assumptions related to their use, that could lead to reduced patient safety and service quality in comparison to permanent staff. This leads to a management dilemma: the risk of not hiring temporary staff versus the risks of using temporary staff. Given staff shortages in healthcare, and consequently the use of temporary staff, managers then have the challenge to find effective ways of minimising any risks when using temporary staff. This requires as a first step a greater understanding of what forms of temporary staff are used and how they are procured. A clearer understanding of the risks when using temporary staff can then be gauged to determine how these risks can be best managed. Townsend and Wilkinson (2010) argued that it was increasingly important to understand the way that people are managed within healthcare, and as a result of the demands of the sector and the continuing pressure to achieve efficiency and other

performance targets, the management of HR practices and the employment relationship is vital to the success of management initiatives.

3.10 General Conclusions

The literature reviewed in Chapter 2 discussed issues relating to the management of temporary employment and its consequences for organizational and individual outcomes. The heterogeneity of temporary employment was discussed, and possible explanations for their use were offered. However, to ensure that organizational output is maintained when using temporary staff, how temporary staff are managed becomes of increased importance. The psychological contract as an example of social exchange has been used as a lens to view research results when discussing temporary and permanent employees and organizational outcomes, and is the theory underpinning the research in this thesis.

Chapter 3 specifically focussed on the management of temporary staff in healthcare, the setting for this research. Healthcare uses a range of temporary employees in an attempt to maintain appropriate staff levels so that patient care is not affected by staff vacancies. However, a management dilemma arises as evidence in the literature suggests that using temporary staff can have negative outcomes for patient safety and service quality, but staff shortages also lead to patient safety concerns. Consequently, if using temporary staff does create risks for patient safety, strategies must be introduced to minimise these risks. What is evident is the difficulties in researching temporary staff in healthcare; trying to identify who temporary staff are and how they are defined, what the effects of temporary staff actually are and how they can be best managed.

The psychological contract as an example of social exchange can be used to provide explanations for temporary employment behaviour and how the employment relationship can be best managed. The employment relationship can be defined as a number of exchanges between the employer and employee, based on the notion of reciprocity – if one side of the exchange is completed, then the receiving party must respond in an equally appropriate way. Current research suggests that two forms of psychological contract may be determined: transactional (based on an economic exchange and associated with temporary staff) and relational (focussing on more social exchanges and associated with permanent staff). However, much of the research surrounding the nature of the psychological contract has adopted an employee perspective to the neglect of the employer and management perspective, and this neglect is particularly apparent in healthcare. Healthcare organizations are under pressure to improve patient safety and to reduce costs and come under constant Government scrutiny. Temporary staff are a significant component of overall staffing and therefore have the potential to make a difference in pursuing these goals. How temporary staff are managed is therefore an important research topic.

Temporary staff in the NHS can be hired for different purposes and for varying lengths of time, usually resulting from organizational demand, with bank (both substantive and non-substantive) and agency staff working alongside permanent employees. This heterogeneity must be considered when discussing the management of the employment contract and the ‘deal’ developed, as this could affect the behaviour of temporary staff, and consequently patient safety and service quality.

The next section discusses the research aims of this thesis and introduces the research questions through which these aims will be fulfilled.

3.11 Research Aims

Healthcare does not employ ‘typical’ temporary staff only; staff can be hired temporarily from an internal or an external source, they can be asked to work on-call, and they can vary in the length of time they are employed and the position they are asked to work in. If applying the tenets of social exchange and the psychological contract, then one would assume that healthcare settings would have a preference for using regular temporary staff and in particular, internal bank staff. These staff have had the opportunity to develop a longer-term relationship with the hospital, and may feel a greater commitment to the organization and their role, in exchange for being hired regularly as a temporary member of staff. Additionally, it may be presumed that temporary staff who are used regularly will also be increasingly aware of the context and environment in which they work, and would therefore pose fewer situational risks. Conversely, temporary staff hired on a more ‘ad-hoc’ basis, and may be unknown to the hospital may have a transactional exchange with the hospital, and as they are more likely to be unaware of their surroundings, could then be perceived by management to be of greater risk to patient safety. The different ‘deals’ offered by management could lead to different patient safety and service quality outcomes, and in an organization where outcomes need to be equal to or better than those of permanent staff, how these deals can be managed and risks reduced becomes of importance.

With limited research undertaken discussing the use and management of temporary employment contracts in relation to patient safety and service quality, this research aims to use the concept of the psychological contract to understand how temporary staff in the NHS can be best managed so as to not compromise patient safety and service quality. The research also aims to develop a model of best practice in the

management and employment of temporary staff, discussing the conditions under which the use of temporary staff will best flourish. The thesis aims to understand why temporary staff are necessary in healthcare and what factors contribute to their use. The research aims to look at the ‘deal’ or exchanges offered to temporary staff, and how this deal can be best managed to maximise patient safety and service quality. In this way, the research aims to extend current literature regarding the management of the psychological contracts of temporary staff, by focussing on the much neglected employer perspective.

3.12 Research Questions

There are two over-arching research questions to this thesis:

1. What are the main challenges and risks to patient safety and service quality in healthcare when using temporary staff?
2. How can these risks be most effectively addressed?

These questions will be explored within the general framework of the psychological contract and addressed by the following more specific questions outlined at the start of the next chapter.

Chapter 4: Methodology

4.1 Introduction

The aim of this chapter is to present a number of methodological issues considered when designing this research and the decisions and justifications made for the methodology that was adopted for the two studies through which the data was collected. Among other issues, general approaches to research in social science and healthcare are discussed, research designs, data collection methods and techniques for data analysis are also reviewed. Details are presented regarding the context of the studies, the process of research, the specific data collection methods used and data sampling. The chapter begins by presenting the aims of the research.

4.2 Research Aims

As stated in Chapter 1, the overall aims of the research were to explore why temporary staff are needed in healthcare, what employment and management strategies are applied to minimise any risks to patient safety and service quality associated with their use and how effective these strategies are. The research also aimed to develop a model of best practice regarding the management of temporary staff in relation to patient safety and service quality outcomes.

Chapter 3 focussed on the use and management of temporary staff in healthcare specifically, presenting the management dilemma centering around the need to hire temporary staff to ensure adequate staffing levels for patient safety, yet simultaneously managing the risks to patient safety associated with their use. The

psychological contract was introduced as a framework for exploring how the management of temporary employees and their organizational relationships could be best maintained to ensure minimum disruption to organizational output, and maximum patient safety and service quality. This research aimed to extend current literature regarding the psychological contracts of temporary staff by focussing on the neglected employer/management perspective.

Within the over-arching research aims there were a number of more specific questions:

- Why are temporary staff used in healthcare, and do different needs for temporary staff result in different recruitment methods?
- Is there a preferred type of temporary staff in healthcare? If so, what management processes need to be in place to ensure these staff are secured?
- What kind of employment relationship and more specifically what kind of psychological contracts do employers seek with temporary staff?
- Is there any evidence of differing exchanges between different types of temporary staff used in healthcare?
- How does the use of temporary staff affect those who work alongside them, and how can this be best managed?

- What are the risks to patient safety and service quality when using temporary staff, and how can these risks be managed to ensure patient safety and service quality?

- What are the characteristics of a model of best practice for managing temporary staff in healthcare?

There are a number of research approaches that could be adopted to address these questions. Before discussing these, it should be noted that the original research aims and design differed to those described in this chapter. During the course of the PhD, the executive directorate and those who had originally supported the research at hospital A all left the Trust. The executive directors who replaced them did not see the planned research topic as a priority and as a result active support to gain access to specific research sites and to relevant data was no longer forthcoming. Given the ESRC Case Award funding for the PhD research linked to the specific hospital, it was decided to persist in the research site but to explore a number of necessary changes in the aims of the research and the way in which the research was conducted.

The research had originally proposed to broaden the scope of current healthcare temporary employment literature by focussing upon the different types of temporary staff found in healthcare, and to define the conditions under which temporary employees will flourish. The research had aimed to look at how environmental conditions, broadly defined to include a range of organizational factors, influenced the motivation, commitment, positive organisational behaviour, competence and team support temporary staff displayed towards an organisation from a temporary employee perspective in particular but also from the perspective of permanent staff

and the managers who chose to employ temporary staff. A distinctive focus, recognising the context of the King's Patient Safety and Service Quality Research Centre within which the research was based, was to identify the consequences for patient safety and service quality of employing temporary staff and to identify the type of temporary staff and the contexts and systems in which they were most likely to be able to ensure patient safety and service quality. Background data was going to be collected on patterns of employment of temporary staff across different divisions with the aim of explaining variations and consequences. A further feature of the originally proposed study was to explore the effects of temporary staff use on permanent staff and this was one feature of the original proposal that was retained in the research that was finally undertaken. The research was going to be undertaken in one hospital (hospital A), to provide an in-depth study of the context and, apart from the analysis of employment data, was expected to use predominantly qualitative research methods including interviews, critical incidents and some observation.

The ED was always going to be included in the study due to the identified problems with staffing in the division, as well as the importance of fast patient care, team communication and team stability. The research was going to compare the ED with another department, where temporary staff were used, but the focus on fast patient care was reduced, and where continuity of care (which had been identified in the literature as important for patient care) was of greater importance. The aim of the comparison was to provide data to identify the conditions under which patient care is best delivered when using temporary staff and to develop a model of best practice to ensure patient safety and service quality when employing temporary staff.

With access to temporary staff and key data rendered impossible but a willingness on the part of some less senior managers at both hospital A and B to take part in the

research, the focus was switched to research the management of temporary staff and the employment relationship with them from a management perspective. This reduced the need to gain access to temporary staff, which had become a problem among some of the temporary staff due to anxieties about staff cut-backs, and focussed instead on the largely neglected management perspective. The relative lack of depth of research access within the first hospital, as well as their distinctive approach towards the employment of temporary staff, meant that some comparative data was desirable. We were fortunate in gaining good access to the Emergency Department in Hospital B allowing for a comparison between two different ways of sourcing temporary staff.

Case Study 2 in the Major Trauma Centre, provided an opportunity to study a distinctive short-term temporary status among consultants during negotiation of a new contract with potentially significant consequences for working hours, quality of working life and work life balance of the consultants, as well as implications for patient safety and service quality. However, as the contracting process extended and the longitudinal study indicated managerial problems when implementing the new contract linked to the decision to put consultants on a temporary contract, the opportunity to compare management approaches to implementation of the new Major Trauma Centres in other London hospitals provided a distinctive research opportunity and became an important and interesting focus within the overall research.

In the next section, these choices are considered within a discussion of different epistemological approaches leading to the justification of the methods chosen.

4.3 Scientific Approach to the Research

4.3.1 Types of Scientific Enquiry

Qualitative and quantitative approaches to research represent two distinctive methodological modes of enquiry in social science research (Bryman, 1992). Quantitative research methods draw upon positivist thinking, entailing a deductive approach to the relationship between theory and research, where there is a focus on the testing of theories (to confirm or disconfirm them) and the assumption of an objective reality (Bryman, 2004). Qualitative research methods are based upon an interpretivist and constructivist approach (Creswell, 2003), with an emphasis on the way in which individuals interpret their social world, and on how views of the social reality are constructed and can change dependent on the individual's perception (Bryman, 2004), reflecting their social, historical or political context (Creswell, 2003). Qualitative research generally aims to develop theory, and is less about testing what is already known (Flick, 2009). The two forms of scientific enquiry differ in the extent to which the research findings are generalizable, with Bryman (2004) noting that in qualitative research the findings are not usually considered generalizable beyond the sample studied. In comparison, quantitative research aims to generalize the findings beyond the particular context in which the research was conducted.

Previous research discussing the management and use of temporary employees has used a variety of methods. Several have used a range of quantitative methodologies. For example, the PSYCONES study, aiming to explore the consequences of temporary workers from the perspective of both workers and employers used a quantitative survey method to gain systematic information across seven countries

(Rigotti, Guest, Clinton and Mohr, 2010). The Royal College of Nursing (2005) reviewed trends in the UK nursing labour market, profiling the nursing workforce at the time, using descriptive statistics of entry rates, and in terms of their description of temporary staff, noted the trends and costs of both bank and agency staff. Aiken et al., (2007) analysed a national sample survey of registered nurses to investigate quality concerns regarding the use of temporary nurses, specifically exploring qualification differences between temporary and permanent nurses.

There are also examples of research exploring the use and management of temporary staff that adopted qualitative methods. Masey, Esain and Wallis (2009) used focus groups to explore nurse shortages and the use of bank and agency staff in an acute care trust. Focus groups were used to increase the knowledge and understanding of factors that led to above or below average use of temporary nursing staff based on the perceptions of those who book staff and middle management. De Ruyter, Kirkpatrick, Hoque, Lonsdale and Malan (2008) used semi-structured interviews to explore in detail why core professionals (focussing on the NHS) were attracted to more flexible methods of working (most notably agency work). Manias, Aitken, Peerson, Parker and Wong (2003), when studying agency workers in acute care settings, used semi-structured interviews with agency nurse providers and hospital managers, to gain an in-depth understanding of perceptions about agency workers.

Quantitative research is typically characterised by being detached from the setting studied, and the subject of interest is measured to determine whether logical patterns exist, and to develop rational theories to explain and predict events. A theoretical framework has typically been pre-selected that guides the inquiry, and only data relating to the pre-selected categories is collected (Hathaway, 1995). In contrast, qualitative research is undertaken by the researcher immersing themselves in the

context being studied, emphasising the importance of understanding the research phenomena from the subjects' perspective to develop an in-depth understanding of a specific situation. The researcher aims to engage in what is being researched and to understand what is taking place (Hathaway, 1995), and research categories and themes emerge from the data. However debates exist about just how emergent the themes are, as a researcher must have some level of knowledge of the phenomenon they are studying and ideas that shape what is being observed.

The present study adopted a qualitative approach to data collection for the following reasons. The qualitative approach allowed for an in-depth study about why temporary staff are used in healthcare, reaching aspects of behaviours, actions and attitudes (and the interactions between the three) that quantitative methods cannot (Pope and Mays, 1995). A qualitative approach allowed for data relating to managing the employment relationships with temporary staff, the risks associated with their use and the implications for patient safety and service quality from a variety of different stakeholder perspectives associated with the management of temporary staff to be collected. The approach also meant that specific patient safety incidents when using temporary staff could be explored in greater detail, as well as examples of when the employment relationship had been managed well/badly. The qualitative approach also meant it was possible to study in-depth any policies and practices that hospitals use when recruiting temporary employees, and to focus on the differences in managerial responses when different types of temporary employees were used. Such in-depth data collection would not have been amenable to more traditional survey or quantitative data collection methods.

As highlighted in Chapter 3, healthcare uses a variety of temporary staff, and the managerial decisions and outcomes associated with their use could vary.

Consequently, this research focussed on the management of different forms of temporary staff in healthcare and the consequences for patient safety and service quality. A first study focussed on the use and management of ‘typical’ temporary staff in two London hospitals. Two hospitals were chosen as they used different approaches to the management of temporary staff recruitment while facing the same type of staff shortage challenges. The study sites were selected as a result of the ESRC CASE award which had negotiated access with one of the sites, and the second site was accessed through negotiations with the HR Manager. Within the hospitals, staff from different organizational levels (executive levels, departmental managers and permanent staff) involved with the management of temporary employees in the Emergency Department (ED) were interviewed. The ED was chosen as a result of the specific challenges of staffing the department – with EDs nationally experiencing staff shortages as a result of which temporary staff are often required. Chapter 3 noted how temporary staff in healthcare could affect patient safety and service quality through a number of factors; however, gaps in staffing provision could also negatively affect patient care, leading to the necessity of using temporary staff. In the ED speed of response and the ability to work under considerable pressure, the capacity to make on-the-spot decisions, to communicate effectively with other team members and to understand departmental protocols is of increased importance. Consequently, how temporary staff are managed could influence patient outcomes significantly.

External factors such as managing temporary staff spend (whilst providing appropriate staffing levels) and adhering to nationally set care standards add to the pressures faced by staff in the ED. Government regulations had previously stated that patients should not have to wait more than four hours in the ED from arrival to

admission, transfer or discharge, with an operational standard of 98 percent used for assessment (Woodcock, Poots and Bell, 2012). However, from April 2011 the four hour government target was replaced with the introduction of new quality care indicators to provide a more balanced and comprehensive view of the quality of patient care provided in EDs (Department of Health, 2009). The four hour waiting time provided the incentive to move patients through the ED quickly, but this was not always counterbalanced with high quality care. The new quality indicators include outcomes, clinical effectiveness and safety as well as the timeliness of service provision, and the removal of the isolated focus on the speed of service, with the hope this would improve clinical outcomes and patient experiences. Even without the main focus on timeliness of patient care, the new quality indicators can still place stressful demands on all staff.

Attempts were made to collect data to provide background context regarding the extent of temporary staff use in the research settings. Requests were made to the HR departments and staff banks regarding data for bank and agency staff use (collected monthly by the hospitals). However, during the course of the research, the study hospitals were attempting to reduce costs, with staffing and the use of temporary staff becoming a sensitive and politicised issue. Consequently they were reluctant to provide staff level and temporary staff figures.

A second study highlighted a unique and distinctive form of temporary employment, the Consultant Resident On-Call (CROC) which arose out of a decision to implement Major Trauma Centres (MTC) in London, providing twenty-four hour a day, seven days a week consultant cover for major trauma patients in London. MTCs had been in development since it was recognised in “Healthcare for London:

A Framework for Action” (Darzi, 2007), that changes and improvements were necessary for trauma care provision in London.

As part of the MTC designation criteria, hospitals had to indicate how they would provide twenty-four hour a day, seven days a week consultant trauma care provision. The CROC necessitated a change in role for consultants, and this study focused on how the launch of the MTC was managed, primarily in one hospital where consultants were temporarily employed on a locum basis whilst awaiting the CROC contract. In essence, they were temporarily temporary. Studying temporary staff at consultant level extends research into temporary employment in healthcare by focussing on a level of staff often neglected in the literature. The study also focused on the consequences of the management decisions, both for the individual consultant locums and for patient safety and service quality. As consultants were interviewed pre and post MTC launch, the study used a longitudinal approach to data collection, focussing on the outcomes of managerial staffing decisions. Although the launch of the MTC was not unique to the main study hospital, the method of its launch was, and consequently it was important to research. Two other hospitals who launched MTCs at the same time were also studied (to a lesser extent) to compare managerial decisions and their implications for temporary staff use.

4.4 Data Collection Strategy

A number of research strategies exist for the collection of qualitative data, depending on the nature of the phenomena being investigated, the research questions asked, and practical considerations in the context of the research. In qualitative research a number of research designs have been suggested including, ethnographies (studying

the research phenomena in the natural setting over a long period of time, primarily through observation), grounded theory (attempting to derive an abstract theory of a process or action, grounded in the view of the participants in a study) and case studies (exploring the research phenomenon in depth, with the case bound by time or an activity) (Creswell, 2003), although these methods are not mutually exclusive, for example, observations can be used within a case study.

The present research used the case study research design, complemented by interviews to test for generalisations. Yin (2003a) stated that in general, case studies are the preferred research strategy when ‘how’ or ‘why’ questions are being posed and when the focus is on a contemporary phenomenon within some real-life context. Case studies are valuable when research questions are investigating real-life situations in detail, or, in particular, studying how and why an intervention succeeds or fails (Keen and Packwood, 1995). The case study arises out of a desire to understand complex social phenomena, allowing researchers to investigate characteristics of real-life events. As a result the case study design can build up in-depth understandings of the phenomena under investigation (Lewis, 2003). There are different applications for case studies: they can be used to explain the presumed causal links in real-life situations that are too complex for survey studies, describe the research phenomenon in real-life contexts, and when interventions are being investigated they can explore the situations that may not have a single outcome (Yin, 2003a). Yin (1999) recommended a case study approach when a context, and potentially the ‘case’ being studied changes over time, or is dynamic, adding to the number of variables to consider in analysis.

Although ethnography would have allowed for in-depth documenting of what was occurring in the natural setting and an exploration of the context in which the

research is undertaken, there are limitations to the ethnographic approach, particularly the practicalities of conducting observations (Green and Thorogood, 2004). The ED is a busy and fast paced environment, and when observing staff, the researcher may have disrupted the provision of patient care. Observations, although helpful in determining interactions between various levels of staff first-hand, and studying what occurs in terms of social actions, relationships, interactions and events (Mason, 2002), would have provided little in-depth information about how and why temporary staff were used and managed, whether there was a preference for the use of specific temporary staff, and determining the views of managers regarding how any risks when using temporary staff could be best managed. Observations are also resource and time intensive. Considering the limited length of time to complete a PhD and the overall research aims, the case study was chosen as the preferred research design. However, the aim was to use the approach in a flexible way and to seek some validation or comparison of the findings by complementing the case studies with interviews in different relevant contexts to provide comparative insights.

4.4.1 Reliability, Validity and Generalising Results from Case Studies

The role of reliability is to minimize errors and biases in a study. Critics of the case study design state that case study procedures have often been poorly documented in the past (Yin, 2003a). In an attempt to resolve this issue, the methods used to collect and analyse data were recorded and documented as clearly as possible.

Concerns regarding case studies have centred around the validity and the generalizability of case study results (the extent to which the results from one case are representative, so that research findings can be applied more generally to other

cases) (Bryman, 2004). Yin (2003a) noted that construct validity was problematic in case study research, but stated this could be overcome by ensuring that the appropriate participants (in this case, managers and those associated with managing and working alongside temporary staff) are included in relation to the aims of the research and are reflective of the research phenomenon. This can be achieved through using multiple sources of evidence.

Yin (2003a) noted that critics who state that single cases provide a poor basis for generalizing results usually contrast the research design to survey research which relies on statistical generalization, whereas case studies use analytical generalization – the generalization of a particular set of results to broader theory. Yin (2003b) therefore highlighted the importance of the role of theory in case study design to situate the case in appropriate research literature to develop the purpose of the case in theory development. Generalizing results is not automatic, and is usually tested through replication, where theory has specified that the same results should occur (Yin, 2003b). However, in part to address some of these concerns, in this research, in addition to the in-depth cases, for one of the studies, interviews were conducted with key informants in potentially comparable settings as a means of exploring generalizability.

4.5 Data Collection Method

There are a wide range of methods for collecting qualitative data, which can be classified into three main groups: interviews, observational methods and analysis of written/visual material (Fitzpatrick and Boulton, 1996). The interview is the most widely used method of producing data in qualitative health research (research

conducted to enhance understanding of health behaviours, health services, and improving the management and provision of health services) (Green and Thorogood, 2004; Britten, 2006), however, interviews can vary in the degrees of the depth of information obtained (determined by the aims of the research), and how the interview is structured. For example, the structured interview consists of a list of specified questions, asked in a specific order in each interview, to generate a set of comparable answers from respondents (Green and Thorogood, 2004). In such interviews, the researcher has decided in advance what constitutes the required data and constructs questions reflecting predetermined categories (Smith and Osborn, 2003). As a result, this method may neglect novel aspects of the research area considered important by the participant, but not previously considered by the interviewer. Additionally, the structured approach can limit the opportunity to unravel the complexities of the research topic and fully engage with the participant's perspective of the topic under consideration. Alternatively, informal interviews are similar to natural conversations, and occur opportunistically in the research field (Green and Thorogood, 2004). These interviews have minimal structure and are interactive in style, but the researcher is at risk of becoming overwhelmed with data if no interview objectives are determined in advance (Fitzpatrick and Boulton, 1996).

The semi-structured interview characteristically involves asking pre-determined questions complemented by further probing by the interviewer, so the interviewee is encouraged to talk freely and extensively about the topics that have been defined by the researcher (Howitt, 2010). Although the semi-structured interview has been described as a form of conversation, it bears little resemblance to natural conversations as the objectives and roles of the researcher and participant are very different (Legard, Keegan and Ward, 2003), and the purpose of the interview is to

ensure that relevant topics are brought into focus so that knowledge and data can be produced (Mason, 2002). The ordering of the questions in a semi-structured interview is not as important as in structured interviews, as the interviewer has the freedom to probe any interesting areas or ideas that arise over the course of the interview. The reliability of the semi-structured interview does not depend upon the repeated use of the same words or the same questions to each participant, but that an equivalent meaning is conveyed to each participant (Barriball and While, 1994).

Focus groups use several group interviews of people who have experiences that are of interest to researchers and generate information from the communication between the participants, this dynamic interaction between the group members and the researcher being the integral part of data collection (Holloway, 2008; Kitziinger, 2006). Focus groups are usually based around a series of structured questions, with the investigator acting as a moderator among the respondents, encouraging full participation from those involved and aiming to keep the discussions flowing (Wilkinson, 2003). Focus groups provide the opportunity to acknowledge the natural language of a particular group of participants, and may encourage those who feel inhibited by interviews to participate in discussions. However, some participants may feel inhibited by the sensitivity of certain research issues, there is no clarity as to the effects of group conformity in expression of participant's views, and it may be harder to probe for further details of views and experiences in focus group conditions (Fitzpatrick and Boulton, 1996).

Interviews are helpful for reporting beliefs and attitudes, and individuals may talk about actions and behaviours, however, observations can provide data to verify if what people say they do, actually occurs (Pope, Ziebland and Mays, 2006). As with interviews, observations can vary regarding the level of intrusiveness of the

researcher. An advantage of observation is gaining access to behaviours that participants may be unaware of, or produce a biased account of. However observations are labour intensive, both in terms of data collection and analysis, as prolonged observation in the field is necessary to learn about the setting and the people involved (Holloway, 2008), and observations could be prone to a researcher bias in selecting what is being observed (Fitzpatrick and Boulton, 1996).

Written sources and documentary evidence can also be used to provide data relating to the research. Documents, either visual or textual, are created in particular contexts, with a specific purpose (Mason, 2002) but such documentary evidence can provide background context of the setting or the research population in question (Green and Thorogood, 2004). Documentary evidence can include sources such as public records and official statistics, which can provide a rich source of quantitative secondary analysis, or can be used to discuss what an organization considered to be important at a particular time, how classification of issues have changed and the changes which have occurred in the research setting over time (Green and Thorogood, 2004). Documentary evidence may include protocols and meeting minutes from the research setting, providing evidence for contextualisation as to why specific practices in the research setting are undertaken, and why policy decisions were made. However, when using documentary evidence, the researcher is limited to what is available or accessible to them and the researcher has no knowledge or control over how the data was collected or the accuracy of the reporting (Green and Thorogood, 2004).

Using participant diaries is a method of collecting documentary evidence thought to provide accurate data reducing the effects of recall, improving the ability to determine the order of events and consequently can elicit more comprehensive

description of particular events (Hoppe, Gillmore, Valadez, Civic, Hartway and Morrison, 2000). However, the authors also noted limitations to diary data collection methods including the burden placed on participants, leading to decreasing co-operation in the study, participants may become sensitized to the study and change their behaviours accordingly, and the volume of data collected in diary studies could complicate analysis.

To meet the aims of this research, it was judged that data collected with the use of semi-structured interviews was most appropriate, as they allowed for flexible topic-guides and open-ended questions and the method encouraged the opinions of the research participants to be explored (Pope, van Royen and Baker, 2002). This flexibility also allowed for the eliciting of views and additional issues or concerns to be uncovered, which had not been previously considered or anticipated by the researcher. The method of data collection meant that the interviewee's own framework and meaning of the topic under consideration could be explored without imposing the researcher's own assumption onto them (Britten, 2006). Probing allowed for the clarification of interesting and relevant issues, exploring more sensitive issues and exploring inconsistencies within respondents' accounts (Barriball and While, 1994). As a result, the method was considered suitable when researching the use and management of temporary staff, the risks associated with their use, and how these risks could be best managed.

One of the fundamental principles of semi-structured interviews is to listen to what the respondent is saying, trying to understand the subtext of what needs to be explored (Legard, Keegan and Ward, 2003). As the semi-structured interview is interactive in its nature, full attention is required from the researcher. If the researcher attempted to write down everything the participant stated, there is the

potential for only capturing the general idea of what had been said, missing important topics and ideas and note taking can interfere with the smooth running of the interview (Smith and Osborn, 2003). Kvale (1996) added that without recording interviews, there was the potential for rapid forgetting of certain details and the influence of selective memory.

It has been argued that there may be some situations where written notes could be preferable, especially if respondents take a while to feel at ease with the situation and recording equipment and consequently do not speak freely regarding the research topic (Britten, 1995). A dated article, (Belson, 1967), discussed concerns when recording interviews and its effect on the accuracy of interviews, including respondent reactions when asked to discuss personal situations, and whether they would suppress information, refuse to respond or decline to take part. Even within more ordinary questioning and topics of discussion, there is still the possibility that respondents could display some adverse reactions to recordings, including the fear of being recorded, developing a wariness about why data needs to be recorded, or changing their approach to the formality of the research, influencing the accuracy of their responses. Lee (2004) discussed the impact of recording devices in interviews and concluded that recording of interviews has now become an issue of practicality (in terms of achieving reliable data for analysis), yet there have been few sustained attempts to develop an awareness of how recording methods affect the research process.

For this research, the decision was made to use digital recording when conducting interviews, ensuring a detailed and accurate record of the interview, aiding data analysis, and limiting disruptions to the flow of the interviews as a result of note-taking. To reduce any effects of wariness of recording equipment, each participant

was asked if they were willing to be recorded and provided written and verbal consent to be recorded, with the understanding that all responses would be anonymised. Respondents were reassured that they could withdraw at any time, and did not have to answer questions if they felt uncomfortable. It was hoped that these measures made the respondent feel at ease in the research environment.

Attempts were made to obtain other sources of evidence to cross validate the data collected through semi-structured interviews. Information regarding permanent and temporary staffing levels and protocols and procedures related to the management of temporary staff were requested from the case sites. Although it was mentioned both pre and during interviews that this information would be provided, the documents were not produced. Informal observations were conducted in the settings when waiting for interviews, providing complementary evidence regarding the pressures faced by staff in the ED.

4.6 The Studies and their Context

4.6.1 Context of Study 1: The Management of ‘Typical’ Temporary Staff in Emergency Departments

Study 1 examined the management of ‘typical’ temporary staff in the Emergency Departments (EDs) of two large and very busy London hospitals.

4.6.1.1 Background to the Hospitals

Hospital A

Hospital A is a major NHS Foundation Trust and teaching hospital in London which provides both comprehensive local services and specialist services. The hospital uses NHS Professionals (NHSP) for the provision of bank and agency nursing, administration and clerical cover and care support staff to the wards (at this hospital NHSP have also taken over the doctor/locum level of service provision, but only for allowing permanent staff at the hospital to take on extra shifts). NHSP is an NHS-run temporary staffing service that was introduced with the aim of reducing the dependency on often expensive agency staff, and improving the quality of care provided by temporary staff (Mercer, Buchan and Chubb, 2010). The hospital is NHSP's fourth biggest client. If no appropriate NHSP staff are available to cover a particular shift, then in accordance with the hospital's instructions, the shift will be covered through temporary employees from approved agencies the hospital has asked NHSP to contact. The ED forms part of the Trauma, Emergency and Acute Medicine Division, which had undergone changes in its management throughout the course of the research. Further information about the context is provided in the next chapter.

Hospital B

Hospital B is also a major NHS Foundation Trust and teaching hospital in London, providing a full range of services for local residents, as well as specialist services. The hospital uses its own internal staff bank for the provision of necessary temporary staff cover. All staff at the hospital are eligible to apply to the staff bank if they

would like to undertake extra shifts in addition to their substantive contract. In an attempt to reduce expenditure on agency staff, the hospital has developed schemes to encourage staff to join the staff bank if they would wish to work extra shifts on a temporary basis. Those not employed substantively at the hospital are also eligible to apply for staff bank positions through the hospital's vacancy recruitment advertisements. Consequently, those who are employed as temporary staff through the staff bank can either be already employed at the hospital and undertaking additional shifts, or those working solely for the staff bank. Agencies should only be contacted to provide staff if no internal bank staff are available. If temporary agencies are used to supply temporary staff, the agency must comply with the London Procurement Programme Framework Agreements.

4.6.2 Context of Study 2: The Launch of Major Trauma Centres in London

The MTC at hospital A provided the main focus, however, hospitals C and D provided a small cross-site comparison of the management of the Consultant Resident On-Call.

4.6.2.1 Background to the Hospitals

Major Trauma Centre provision at Hospital A

Hospital A was nominated as one of four London hospitals to be included in the Major Trauma Project. Hospital A is a major NHS Foundation Trust and teaching hospital in London, providing both comprehensive local service and specialist services. Major trauma patients are cared for in the Emergency Department (ED). The Clinical Director of the Division at the time decided that the CROC should be

drawn from both Emergency Medicine and the Intensive Care Unit, a unique and unusual way of staffing the MTC. As contracts and job roles were being developed, CROC consultants were hired temporarily on a locum basis.

Major Trauma Centre provision at Hospital C

Hospital C is one of London's leading trauma and emergency care centres, as well as being home to numerous specialist services. The hospital has an international reputation for caring for some of the most seriously injured patients in London. Hospital C is home to London's Helicopter Emergency Medical Service. A dedicated trauma ward has been running at the hospital since 2005, but the hospital became a designated MTC in April 2010. The MTC was staffed by permanent ED consultants.

Major Trauma Centre provision at Hospital D

Hospital D is a large teaching hospital in London, which offers specialist and community based care as well as acute hospital services. Hospital D was also designated as a MTC in April 2010. MTC staffing is ED consultant based. At the start of the MTC implementation consultant locums were used, however, the hospital had recruited ED consultants to staff the MTC with permanent ED staff.

4.7 Research Sampling

Miles and Huberman (1994) discussed the importance of sampling in qualitative research, noting that small samples are often used (unlike quantitative research), and

that the sample is usually nested within the research context and studied in-depth. Sampling for case studies can be purposive (selected as they are typical of the particular phenomenon or intervention being investigated), or theoretical (chosen to specifically confirm or refute a hypothesis that has arisen from previous research). Different groups within the study sample may have legitimate, but different interpretations of events and because of this, must be included (Keen and Packward, 1995). Case study research benefits from the expert input from those with most knowledge of the subject under investigation.

4.7.1 Sampling in Study 1

In this study, the sample consisted of those able to provide the management perspective on the employment relationship with temporary staff, including those in executive positions who led on workforce issues, managers of the staff banks used by the hospitals, those in clinical managerial positions in the ED and permanent staff who worked alongside temporary staff, who in a sense have to manage temporary staff on a shift-by-shift basis. The clinical managers helped to identify the permanent staff used in the study. In this way, the sampling is similar to that of 'quota selection' (Miles and Huberman, 1994), in that the major subgroups are identified, and representatives of that sub-group then interviewed.

Although, it would have been helpful to have interviewed temporary staff to gain their perspective on the way they are managed and their employment relationship, there were a number of reasons why temporary staff were not included. During the course of the research, both hospitals were attempting to make financial savings, and staff cut-backs and temporary staffing became a politically sensitive topic. Even

though temporary staff were ensured participant confidentiality and anonymity when reporting data, they were generally unwilling to come forward to take part in the study. Secondly, access to temporary staff had to come through those who hired and managed them (be that clinical managers, the staff bank or the temporary staff agencies). Information regarding the study and researcher contact details were sent through gate-keepers at the hospitals, and consequently there was little control over when and to whom the information was sent, and how any queries regarding the research were followed up. Difficulties in accessing certain informants may arise due to concerns about threats to the reputations of the organization, careers and individual reputations (Harris, Kelly, Hunt et al., 2008). Finally, the research aimed to report upon the management perspectives of temporary staff, gaining access to those involved in management decisions at various staffing levels, and those who work alongside temporary staff and interact with them on a daily basis were prioritised.

4.7.2 Sampling in Study 2

The main participants in this study were the consultants who had been asked to become a CROC in hospital A to gauge their perspective on the management of the MTC. This consisted of consultants from both the ED and the ICU. All consultants who had been asked to participate in the CROC were invited to take part, in addition to the managers of the ED and the ICU.

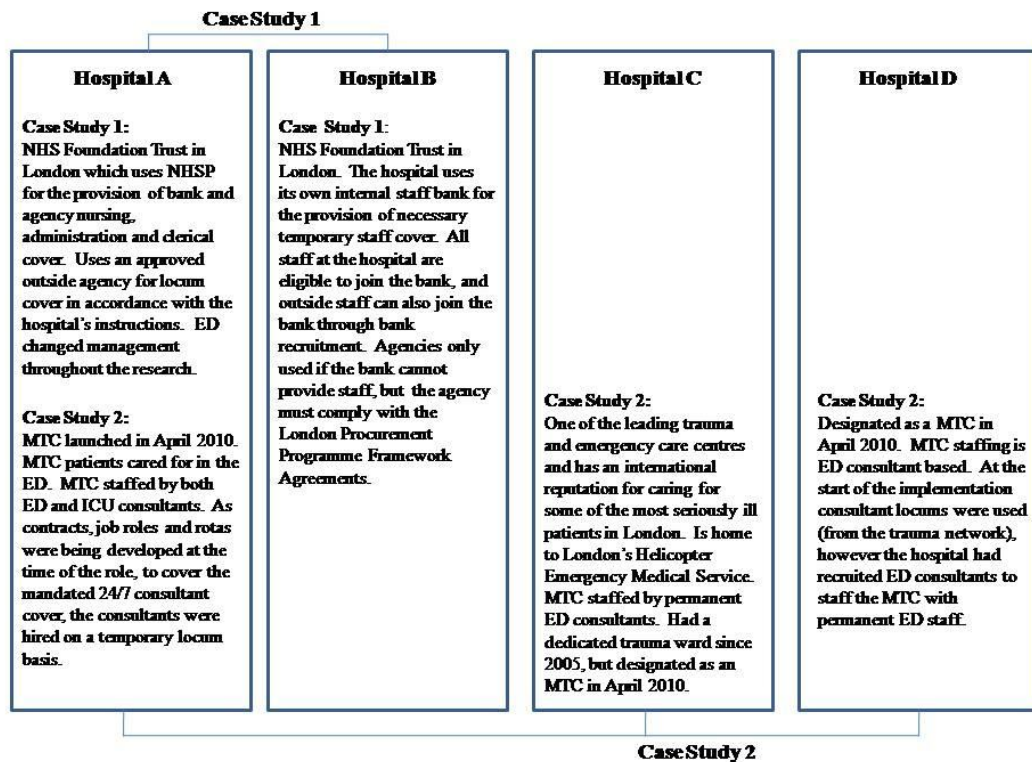
At data collection time 2 (post MTC launch) all consultants from both departments were once again contacted, including consultants who were new to both departments, employed since the introduction of the MTC. Further participants were identified

through snow-ball sampling, including staff at the hospital not in the ED or ICU, but who had extensive trauma experience. Two clinical managers (one from ED and one from ICU) at hospital A, involved in the management and development of the MTC were also interviewed post MTC launch, to obtain their perspectives on the management of the MTC and the use of temporary contracts. The clinical managers were not interviewed pre-launch due to the practicalities of working in a busy hospital and managing the change process and staffing changes.

In addition, snow-ball sampling was used to approach those in management positions at hospitals C and D who launched MTCs (officially) at the same time as hospital A. As a result of the time taken in gaining access to the hospitals, interviews were only undertaken with the managers post-launch. To have undertaken a longitudinal approach with consultants in all three hospitals would have been resource intensive, and when considering the limited length of time to complete a PhD, the sample in hospitals C and D were chosen to help fulfil the research aims. Additionally as the aim of the cross-site comparison was to gain comparative information on the strategies used to manage staff in the MTC, the use of a key informant was considered to be sufficient.

To illustrate the range of case studies and the research contexts, these have been presented diagrammatically in Figure 4.1.

Figure 4.1: An Illustration of the Case Studies and the Research Context



4.8 Research stages

The following section outlines the research stages in both of the studies and how each stage related to the research aims and questions.

4.8.1 Research Stages for Study 1

Stage 1 (n = 5)

The first stage consisted of interviews with the Executive Directorate and Human Resource Management level about the use, hiring and management of temporary staff and any policies or strategy related to their use. The purpose was to identify their perceptions of the advantages and disadvantages of the employment of temporary staff with respect to risk management. This stage also included

interviewing representatives from the respective staff banks (hospital A using NHSP and hospital B using an internal staff bank).

The data was collected using semi-structured interviews with the relevant workforce representatives, revolving around themes which had arisen from the review of the literature as important issues to discuss when using temporary staff in relation to patient safety, temporary staff management and ways in which perceived risks associated with their use can be best managed. These included perceptions of the numbers of and reasons for hiring temporary staff in the hospital in general and then focussing on the ED specifically, and a description of the processes and hospital protocols in place to be adhered to when requesting/authorising temporary staff. This set the context for temporary staff use in the hospitals.

The interviews also discussed hospital or staff bank protocols for reporting incidents involving temporary staff, and if there was any evidence to suggest that temporary staff are of greater risk to patient safety and service quality, and what measures the hospitals have in place to reduce any perceived risks. (Interview schedules for Executive Directorate and Human Resource Management level can be found in the Appendix).

This stage also involved interviews with NHSP representatives (the CEO of NHSP at the time of the study, and the NHSP site manager) (hospital A) and the manager of the internal staff bank (hospital B). Questions included context setting, regarding the role of the staff banks in the recruitment and the hiring of temporary staff, their views about why temporary staff were used, if there had been any recent changes in temporary staff use, what protocols are used and implemented when hiring temporary staff, and whether there was a hierarchy of choice regarding the type of

temporary employee hired. Questions then focussed on the ED, and whether there were any distinctive features of the recruitment of staff for the department, and any implications for the employment relationship.

With regards to risks when using temporary staff, participants were asked whether they perceived temporary staff to be a risk to patient safety and service quality, and whether there was any evidence to show that using temporary staff negatively affected patient care. Interview topics included training and development opportunities the respective staff banks provided for the temporary staff, and what their role was in terms of temporary staff induction, the personal development of temporary staff relating to the level of feedback temporary staff received and the opportunity for temporary staff to report issues they encountered. Participants were asked their opinions about how any perceived risks when using temporary staff could be best managed. (See Appendix for interview schedules).

Stage 2 (n=5)

This stage involved interviewing clinical managers in the ED responsible for hiring and managing temporary staff at the departmental level. The interviews provided the opportunity to detail experiences where hiring temporary staff had worked well, and when it failed to produce satisfactory temporary cover, and how this system could be improved. Questions were asked to set the context of the study – including why temporary staff are used, how frequently they are needed, the process through which temporary staff are hired, the roles and activities temporary staff undertake when in the department and if these differed significantly from permanent employees. Participants were asked if there was a preference regarding the type of temporary

staff hired, and if so, why this was the case. To gain further understanding of the context, participants were asked if any other factors had affected the use of temporary staff in the department (both nationally and context specific).

A separate theme discussed the integration of temporary employees into the department and the role of induction (what it includes and if it is offered to temporary staff). Questions sought information regarding the relationship between temporary and permanent staff (and if this differed dependent on the type of temporary staff hired), and in what ways and the extent to which the presence of temporary staff affected permanent staff, and whether this could affect patient safety and service quality. These questions aimed to gain an understanding of the employment relationship between the managers and temporary staff.

A third theme revolved around the evaluation of temporary staff and the quality of care temporary employees provide. As healthcare uses a variety of temporary staff, managers were questioned regarding any differences in attitudes, behaviour and quality of care provided by the different forms of temporary staff, and whether this differed to permanent staff. Respondents were asked to describe critical incidents where relevant.

Managers were asked how and in what way the presence of temporary employees effected patient safety and service quality, and what data indicated that patient safety and service quality was reduced when using temporary staff. A critical incident technique was used to provide examples showing when temporary staff led to positive and negative outcomes for patient safety. Questions sought to understand how managers thought any real or perceived risks to patient safety and service quality could be best managed. (See Appendix for interview schedule).

Stage 3 (n = 9)

The third stage obtained the perceptions and experiences of permanent staff who worked alongside temporary staff. As noted in Chapter 2, evidence is accumulating indicating that temporary staff may affect the behaviour of permanent staff who work alongside them (Connelly and Gallagher, 2006, George, 2003, Pearce, 1993), consequently it is necessary to capture their perspectives. Literature suggested that in healthcare, permanent staff felt they should induct new staff, orientate temporary staff, or undertake duties temporary staff may be unable to complete (Hoque et al., 2008, FitzGerald and Bonner, 2007, Hass et al., 2006). If this is the case, it was important to determine how this influences their behaviour, employment relationship and psychological contract, and patient safety and service quality.

Permanent staff were asked for their perceptions about why temporary staff were used in the ED, if they had a preference for the type of temporary staff they worked alongside, and whether suitable temporary cover was arranged. Questions regarding the similarities and differences between the various forms of temporary staff found in the ED, and the consequences for patient safety and service quality were asked.

Permanent staff were also questioned regarding attitudes, behaviours and commitment of temporary staff, and asked, if possible, to provide examples of positive and negative uses of temporary staff in the ED. Respondents were asked for their perceptions regarding how the presence of temporary staff affects patient safety and service quality, the risks associated with their use and how the identified risks could be best managed. Critical incidents were used to identify cases when temporary staff had either positive or negative effects on patient safety and service quality.

Additionally, permanent staff were questioned about how temporary staff were integrated into the department, whose responsibility it was to provide an induction (and whether inductions were given to temporary staff) and what it should include. As the literature had identified that the roles of permanent staff change as a result of temporary staff use, permanent staff were questioned about extent of their role changes and how this affected their employment relationship and psychological contract. (See Appendix for interview schedule).

4.8.2 Research Stages for Study 2

To meet the aims of this study a longitudinal qualitative approach was chosen for the reporting of the consultant's perceptions of the management of the MTC launch (especially the temporary nature of the consultant's contracts), specifically for hospital A. Hospitals C and D were also included in the study, but due to the practicalities of the research and gaining access to participants, representatives from these hospitals were interviewed once following their MTC launch.

Qualitative longitudinal research seeks to uncover and understand processes and responses to change and is important where individual behaviour is key to achieving the goals of the change (Corden and Millar, 2007). Thomson (2007) added that qualitative longitudinal research offers the opportunity to develop a more complex and realistic understanding of the situation, why individuals act as they do, and in case of policy and projects, their intended and unintended consequences. Longitudinal qualitative research explores the broader context within which a change is occurring and the range of factors that the participants believe to be contributing to the change or the outcome (Lewis, 2007).

Semi-structured interviews were used to gather the qualitative data both pre and post MTC launch.

Pre-Launch (n=13)

Interviews were conducted with consultants from both the ED and the ICU. Background and context questions were asked relating to their current role and preferred working hours, to understand how the launch of the MTC would affect their work schedules.

Questions then focussed on the MTC and CROC launch, establishing the consultant's perspectives about why the MTC was introduced, whether they agreed with the aims of the MTC and if the hospital was ready for its implementation. Consultants were asked about what they perceived the positive and negative impacts of the MTC and CROC would be, and if necessary, were prompted to think about their responses from an organizational, personal, professional and patient safety and service quality perspective. As the CROC entailed having to remain in the hospital for twenty-four hours, consultants were questioned how they perceived the new rota would affect their work-life balance and quality of working life. Long-term implications (considered at an organizational, personal and patient safety level) and contingency plans (for covering illnesses/vacancies) were also discussed.

The third part of the interview revolved around the management of the change process and the development of their contracts in an attempt to gain their perceptions regarding the necessity of the temporary contracts, and the implications of this process for employment relationships and the psychological contract. Questions

included their involvement in the consultation process and how well they were informed about the launch. (See Appendix for interview schedule).

Post-Launch (n=12)

Post-launch interviews aimed to elicit views regarding what had occurred in the time period between interviews, to discuss any developments in the management of the temporary contracts the consultants were hired on during the MTC launch and any implications this had for patient safety and service quality. How the process could have been best managed to reduce the time spent on temporary contracts was also discussed.

The first section of the interview sought information regarding role change since the MTC launch and whether the changes were better or worse than expected. Questions included the consultant's perception of the level of trauma cases, and their knowledge of extra resources implemented to help with the running of the MTC.

The second stage concerned the consultant's experience of being a CROC and any effects of the CROC for patient safety and service quality (through the use of clinical examples). Consultants were asked how undertaking the CROC affected their quality of working life and work-life balance.

A third stage referred to the development of new teams, integration and communication, how communication had developed through the introduction of the role, and whether the temporary contract affected the level of communication between management and the consultants.

The interviews discussed the long-term change and management of the process, including questions relating to the necessity of temporary contracts for CROC's, the sustainability of the CROC and the management of the change process. This included the role of management in developing the consultant contracts, why they were hired on the temporary basis, and what impact this had on the operation of the MTC and their employment relationship. The interviewee had the opportunity to discuss any other issues regarding the launch of the MTC the researcher had not considered. (See Appendix for interview schedule).

The post-launch stage also involved semi-structured interviews with a manager from both ED and ICU, to elicit a management perspective regarding the MTC launch, why the consultants were temporarily employed on locum contracts, and their perceptions regarding patient safety and service quality outcomes. The interviews aimed to gain the manager's perspective regarding why the MTC was implemented, the management decisions for using two departments to staff the MTC, why the contracts and job plans were delayed, and the impact on the employment relationships of the staff involved. Questions were asked to ascertain whether the MTC had led to improved patient safety and service quality, and what evidence they had to confirm their perceptions, especially in relation to hiring consultants on a temporary locum basis, in comparison to recruiting external temporary staff. The interviews discussed long-term plans for the MTC, its sustainability if it continued to be staffed on a temporary basis, and the impact that staffing the MTC in this manner had on other areas of the hospital. (See Appendix for interview schedule).

It should be noted that throughout the post-launch stage it was clear that the MTC implementation was not complete, and there was scope for a third stage of interviewing with consultants when the contracting process was completed. Due to

the limitations of having to complete the PhD within a specified time frame, a third stage of interviewing was not conducted (even though some consultants had displayed an interest in a third round of interviews).

4.8.3 Interviews with Hospitals C and D

Hospitals C and D were officially designated as MTCs at the same time as hospital A. For this reason, representatives at hospitals C and D ($n = 2$) were interviewed about their MTC launch, how the process occurred in the respective hospitals to compare and contrast the management practices and potential patient safety and service quality outcomes.

Questions were asked to the participants to set the context, establishing their role in the management and development of the MTC in their hospital, to see if there were any differences in the how MTCs were launched, identifying how hospitals C and D ensured twenty-four hour consultant cover, and what the processes were to develop appropriate cover – whether new contracts needed to be negotiated, and what the consultation process was like. Both hospitals were asked whether there had been positive patient safety and service quality outcomes as a result of the MTC. Positive and negative organizational outcomes as a result of the MTC were also explored.

As the CROC was a major change to the working patterns of consultants in hospital A, affecting staff morale and the employment relationship, the management of hospitals C and D were questioned about staff morale, quality of working life and the work-life balance of their consultants. As the aim of the MTCs was to improve patient safety and service quality for major trauma patients, hospitals C and D were asked whether there had been improvements in patient outcomes since the MTC

launch. As all three hospitals implemented the staffing of the MTC differently, they were questioned about whether they had been in contact with the other hospitals to discuss the MTC launch, and if there was a method that was most appropriate for providing twenty-four hour care.

These interviews were included as they provided the opportunity to compare the management of the staffing of the MTCs, and if the unique method used in hospital A could have been improved to ensure better employment relationships with consultants, patient safety and service quality, and how the management of the launch, especially the nature of the contracting could be improved. (See Appendix for interview schedules).

4.9 Data Analysis

All interviews were digitally recorded and transcribed verbatim. Thematic content analysis was applied to the qualitative analysis of the data. Bryman and Burgess (1994) noted that the analysis of qualitative data may be regarded as problematic and seen as voluminous, unstructured and unwieldy. Ritchie and Spencer (1994) discussed qualitative analysis in applied research in policy, where objectives of the research are set and shaped by clear research and information requirements. In this way, research output needs to provide some answers; *'in the form of greater illumination or understanding of the issues being addressed'* (page 175). Green and Thorogood (2004) stated that thematic content analysis aims to report the key elements of the respondent's accounts.

Braun and Clarke (2006) defined the inductive approach to thematic analysis, when the themes identified are strongly linked to the data and not driven by the

researcher's theoretical interest. The themes and categories developed may bear little resemblance or relation to the questions asked of the participants. However, Braun and Clarke (2006) acknowledged that researchers may not be able to completely free themselves from their theoretical or epistemological background. The deductive or theoretical approach to theme detection tends to be more focussed by a researcher's theoretical or analytic interest. Pope, Ziebland and Mays (2006) conceded that in practice researchers will move between both induction and deduction in the same analysis.

Thematic content analysis includes a number of stages beginning with data familiarisation and looking for patterns, ending in the reporting of themes. Braun and Clarke (2006) identified steps to thematic analysis including: familiarisation with the data, generating initial codes to organise the data in a meaningful way, searching for themes through analysing the codes and then reviewing the themes to ensure they encapsulate the meaning of the data.

Transcripts from all participants were initially open coded to identify emerging issues and to compare the codes across participants, seeing how accounts varied and classifying common issues in the data set. This was an iterative process, reviewing data sets in light of new codes and ideas emerging throughout the analysis. Having become familiarised with the data and developed a coding scheme, codes were organised into overarching themes by looking at the relationships between the codes. The themes were then defined, and the data was re-analysed to ascertain whether the data still fitted the defined themes meaningfully, ensuring there were clear distinctions between the themes. This was also an iterative process, involving decisions about which data segments were relevant to the identified themes (and

seeing if new themes emerged), refining the themes and going back to the data to ensure they represented the data accurately.

Green and Thorogood (2004) noted that thematic content analysis can be quite basic, and could move from basic coding and categorising of data towards asking more complex questions about how elements of data are related. This was particularly relevant in this research as different levels of staff were interviewed from different hospitals in both studies. To be able to see across the data, the data was charted, re-arranging it according to the themes identified, with entries made for each respondent in the chart. This process of data analysis was used in both studies. This is similar to the charting stage in Ritchie and Spencer's (1994) Framework Analysis. From these charts I was then able to map the key characteristics of the data from the various levels of staff interviewed within both studies, in an attempt to provide answers to the research questions and overall aims of the PhD research.

To facilitate the analysis, the qualitative data analysis software programme NVivo (version 9) was used. The software helped to manage the large data set, and aided with the organization, storage and retrieval of relevant data. All transcribed interviews were uploaded into the software, and the data was coded as described above. This aided the exploration of the data, allowing for relevant excerpts to be found, and not just those specifically noticed or remembered.

Qualitative analysis is sometimes criticised for its lack of rigour. Criticism of qualitative analysis comes primarily from quantitatively focused researchers, as they evaluate analysis techniques against the positivistic criteria of reliability and validity (Mays and Pope, 1995). Patton (1999) argued that statistical analysis follows formulas, while the core of qualitative analysis is a creative process dependent on the

insights and conceptual capabilities of the analyst. Mays and Pope (2000) argued that as qualitative research and analysis is a distinctive paradigm, it cannot and should not be measured and judged by the conventional, and positivist notions of validity, generalisability and reliability. Consequently, when undertaking qualitative analysis, other methods have been developed when discussing the trustworthiness of the data (how consistent and accurate the data analysis is). Trustworthiness is based around criteria including how credible the study and analysis is, how dependable the results are (Shenton, 2004), and the rigour and consistency of the research analysis, ensuring accurate data interpretation (Franklin, Cody and Ballan, 2010).

The credibility of qualitative analysis is based upon whether the findings explain what is occurring in the reality of the situation (Shenton, 2004). This could be achieved by undertaking peer scrutiny of the research analysis. This provides a fresh perspective to challenge the research and analytical assumptions by individuals who are detached from the research project. Assessing for rater agreement of themes is an approach for developing qualitative rigour in analysis (Mays and Pope, 1995), and this ‘analyst triangulation’ (Patton, 1999) can help to overcome scepticism surrounding qualitative data analysis. An alternative way of determining credibility is to look for deviant cases (Mays and Pope, 2000), and consider if the argument is weakened by the deviant cases, or if further themes should be considered. Finally, credibility can also be determined by providing a clear account of the coding structures and the concepts developed, and presenting sufficient data to allow the reader to judge whether the interpretations adequately support the data (Mays and Pope, 2000). This can also reduce the opportunity of recall and memory bias when reporting results (Franklin, Cody and Ballan, 2010).

The dependability of qualitative analysis questions whether, if the research was repeated, similar results would be obtained. A clear description of the analysis process is required, ensuring rigorous and consistent analysis techniques have been used, together with documentation regarding how analysis decisions were made and interpretations evolved.

In order to ensure that a rigorous analysis of the data was conducted, clear steps in the analysis were undertaken: an initial coding framework was developed, which then led to the identification of themes within the data, with the iterative approach undertaken to ensure codes and themes were updated. A researcher, external to the PhD research was consulted to verify the coding framework, and to overcome any doubts within the coding framework. The use of an additional researcher, new to the data, had the added advantage of uncovering new themes and insights that may have been overlooked from a single perspective (Patton, 2002) and added further validity and rigour to the results by reducing the possibility of researcher bias.

4.10 The Role of the Researcher

In qualitative research, there is recognition that the researcher is part of the process of producing data and their meaning (Green and Thorogood, 2004) and the presence of a researcher can influence the data obtained (Murphy and Dingwall, 2003). It is therefore important to reflect upon the role of the researcher and be aware about how feelings and behaviours can influence what is being studied.

During the course of the research I felt aware that undertaking interviews would take up valuable time for the participants; however, despite this, those who participated were fully engaged in the research. This was evident in study 2, where many of the

consultants who participated in the pre-launch stage were keen to undertake a follow-up interview. I ensured that interviews took a minimal amount of time, and that any phone calls and e-mails were kept to a minimum to avoid taking time away from their day-to-day responsibilities.

It is difficult to measure the impact of the questioning on the truthfulness of the accounts provided by the respondents. However, when engaging participants in the research and throughout data collection, I was aware of the nature of our interactions and attempted to ensure the participants were willing to be interviewed. Semi-structured interviews provided the opportunity to engage with the research participants and discuss issues in-depth in a way that would not have been possible using a quantitative approach. When describing my research and having provided participants with the information sheet, informal discussions with participants confirmed that the research was timely and critical, providing an indication as to why they were engaged with the research. Developing relationships with participants also facilitated further staff engagement and assisted in gaining access to interviewees. However, the particular sensitivities associated with temporary staff at a time when financial cut-backs in the NHS are occurring also meant that participants who would have added to the research findings expressed concerns and were unwilling to participate.

4.11 Ethics

For both studies, proposals for the research were reviewed by the hospital's research ethics committee, and were classed as service evaluation, and as a result fell outside the remit of NHS REC. The research also went through King's College London's

Education and Methods Research Ethics Panel where it was granted full approval. R&D was approved from the studies sites. Before all interviews, participants received an information sheet outlining the study and making it clear that they were free to withdraw from the study at any time. Respondents were invited to ask questions prior to participating, and all participants were asked for verbal and written consent. Data confidentiality was maintained in accordance with Data Protection Act 1998 and interview transcripts were stored securely in locked cabinets.

4.12 Methodological Conclusions

This chapter has discussed a number of methodological issues that were considered when undertaking this research and presented a justification for the methods adopted. The case study approach using semi-structured interviews for data collection was chosen as this provided the robust data to answer the research questions posed. The method allowed for an in-depth study of the management of temporary staff, and the launch of the MTC and how any risks can be best managed. The use of thematic content analysis allowed for a rigorous examination of the data, with the development of themes that were common among participants identified, with the opportunity to determine how these themes relate to theory. The following chapters present the results of the two studies.

Chapter 5: Findings of Study 1: The Management of ‘Typical’ Temporary Staff in Emergency Departments.

5.1 Introduction

This chapter presents the findings of study one, investigating the management of ‘typical’ temporary employees in the Emergency Departments (ED) of two London hospitals. While the nature and justification of this study was discussed in Chapter 4, it is worth recalling the key features. The main aim of the study was to explore the EDs use and management of temporary staff, and to assess their impact on patient safety and service quality. As stated in Chapter 1, there is a need for co-ordinated patient care in all hospital contexts, but in EDs, where rapid decision making is important, and patient waiting time targets are on Government agendas, co-ordination and effective utilisation of all staff, be they permanent or temporary, to ensure optimal patient care is particularly challenging.

Since staff shortages are constantly occurring for a variety of reasons, hospitals use temporary staff in an attempt to ensure the patient-to-staff ratio is maintained to a standard where patient care is not compromised. However, the literature has provided evidence that temporary staff lead to risks to patient safety and service quality (Audit Commission, 2001; Adams and Bond, 2003a; FitzGerald and Bonner, 2007). The study aimed to gain an insight to the nature of these risks as perceived by key members of the EDs, to understand how they sought to minimise the risks and if there are differing exchanges between different temporary staff used in healthcare.

The two hospitals provide a useful basis for comparison since they use different methods for sourcing and hiring temporary staff.

5.1.1 Structure

This chapter reports the results of interviews conducted with staff at two London EDs. The sample characteristics, data collection method and analytic framework within which the issues are discussed are described, as well as a brief description of the characteristics of the two EDs. Themes that arose through the analysis are discussed with reference to the different levels of staff interviewed, and comparisons are made between the two hospitals.

The first main section of results presents findings about why temporary staff were used in EDs, highlighting differences in attitudes between managers and clinicians in their priorities regarding temporary staff use. The policies, procedures and practices in the hiring of temporary staff at both hospitals are explored to assess how far they are able to minimise the risks to patient safety and service quality when using temporary staff.

The next section describes the ways in which temporary staff were perceived to be of risk to patient safety and service quality, including their familiarity with the ED environment, the role of team familiarity and team stability and the training and development of temporary staff. How temporary staff could affect permanent staff is also discussed. The measures that both hospitals have in place to reduce risks are reported. The behaviour and commitment of temporary staff and the psychological contract of temporary staff are also discussed.

Finally, the results are discussed in relation to broader issues when considering staffing in healthcare, including incentive structures and pay, policies to cut staffing costs and problems of staff vacancies, as well as the nature of staffing during particular time periods (e.g. weekends).

The analytic framework within which the issues are explored is the psychological contract - a lens through which the employment relationship can be explored. If an individual perceives their psychological contract to be broken, their motivation, morale and commitment to an organization may reduce, and in healthcare this can have implications for patient safety and service quality. The 'deal' between managers and temporary staff then becomes important and how this 'deal' is developed, maintained and managed is of importance when discussing how to manage risks associated with temporary staff.

5.2 Sample Characteristics

Three different levels of staff were included in the study, all involved in the management of temporary staff. Executive level managers associated with workforce issues were interviewed to provide an insight into hospital policies with regards to temporary staff use, and general staffing issues. Clinical Managers at the departmental level were interviewed to understand local issues concerning temporary staff. Thirdly, permanent staff working alongside temporary staff and interact with them on a daily basis were interviewed to provide a more operational analysis of the implications of working with and sometimes supervising temporary staff. When relevant staff had been identified, they were personally invited to take part in the study. Participation was voluntary, and full informed consent was given before the

interviews were undertaken. Although attempts were made to interview temporary staff, barriers presented by key gate-keepers at both hospitals made it clear that this would be problematic. As a result, this was abandoned. This was not considered to be a major disadvantage as the research questions focussed on the management of temporary staff, consequently staff with some form of management role were considered more important to focus upon.

In hospital A, interviews were conducted with: the Associate Director for Workforce Resourcing, the on-site NHSP representative, the CEO of NHSP, the Clinical Director for Emergency Medicine (responsible for hiring and managing consultant locums in the ED), the EDs Administrative Service Manager (responsible for the administrative and clerical staff in the ED) and six permanent ED staff who worked alongside temporary staff. Of this sample 7 were male, and 4 were female.

The ED at hospital A comprises of 5 areas: resuscitation (where the most sick and injured patients are treated), majors (looking after patients who are stable but have a major illness or injury), minors (patients with non-life threatening conditions), paediatrics (a specific area for children in the ED) and the clinical decisions unit (for adult patients who need a short period of treatment or observation). Attempts were made to access ED data regarding staff levels, vacancies and temporary staff use in the department. However, the department and HR were unwilling to provide this data. NHSP were approached about the levels of temporary staff they provide the ED; however, access to the data was also blocked by the department. Based on our initial enquiries, there was some suspicion that no one was very confident about the information systems for staffing, noting that the figures were very volatile and this may partly explain the reluctance to provide data. The limited data that was scrutinised, highlighted major discrepancies between vacancies and hours worked by

temporary staff, and enquiries highlighted that inaccuracies were also evident between the hours worked by and the hours paid for temporary staff.

In hospital B, interviews were undertaken with: an HR Manager, the Internal Bank Temporary Staffing Manager, the Head of Nursing for ED, the ED Clinical Lead, the ED Matron and three permanent members of staff (of varying levels of seniority) who worked alongside temporary staff. Of this sample 4 were male and 4 were female.

At hospital B, there is a resuscitation and majors area. The minor unit is based at another location; however those with minor injuries may enter the ED when the minors unit is closed (between 4pm-8am). Hospital B also has an area in the ED specifically for children. Data about staff levels, vacancies and use of temporary staff was not provided by the hospital.

Interview topics included the hiring and management of temporary staff, focussing on reasons for using temporary staff, the methods adopted by the hospitals to hire temporary staff, temporary staff integration, risks to patient safety and service quality when using temporary staff, how these could be best managed. Policies and practices used when employing temporary staff were discussed. Participants were asked for critical incidents when patient safety or service quality was affected when using temporary staff. Semi-structured interviews allowed for probing of responses and clarification of information. The researcher was conscious of the pressures on ED staff and the limited time available for interviewing. (Interview schedules in Appendix)

5.3 Reasons for Using Temporary Staff

This section presents results from participants at hospitals A and B concerning why the EDs hired temporary staff.

Cover for Vacancies and Other Forms of Absence

In both hospitals the Associate Workforce Director (AWD) and HR Manager (HRM) provided similar explanations for using temporary staff. Managers at this level outlined tolerance levels for vacancies (hospital A having a desirable level at 5 percent and hospital B's was 10 percent, although they try to keep levels below this). The rationale behind these tolerance levels was to control fixed labour costs, meaning that: *"Temporary workers, in that sense, are an asset for taking up that five percent"* (AWD, Hospital A), although, it was conceded that in reality, temporary staff take up a greater proportion of staff employment. Similarly, in hospital B the tolerance levels meant that temporary staff were a, *"Buffer, so we can flex it (a ward) with activity"* (HRM, Hospital B). Temporary staff provided an organization with flexibility in an effort to control labour costs, yet still provide adequate staff coverage.

Both managers discussed recruitment difficulties as a factor leading to temporary staff use: *"We've had recruitment difficulties, particularly with doctors, so it's been a challenge...and we're probably running at about 300 nurses (across the hospital) light"* (AWD, Hospital A). However, hospital A stated that staff sickness was the main reason for their use, and was an on-going issue. A side-effect of this was work intensification for staff if the shift was left unfilled. Temporary staff were also used to cover shifts as a result of absence, holidays and training.

Even when an employee had been recruited to a vacant position, temporary cover was still necessary as, *“It takes about three months to get a person in once you’ve advertised, interviewed and done all the checks” (HRM, Hospital B)*. For consultant level staff, hospital B used locums on long-term contracts to assess their skills and fit into team structures, with managers essentially using the locum contract as a probationary period, also giving the locum the opportunity to determine whether they would like to become a permanent member of staff.

Need for Service Delivery

Managers at hospital B discussed the need to reduce the number of bank and agency staff used as a result of cost saving measures (both hospitals acknowledged that agency staff in particular were more expensive than permanent staff). However simultaneously control measures had been introduced to ensure staff levels were matching patient acuity levels. Here, the cost vs. safety dilemma was evident, but the pragmatic need for staffing was clear: *“If there was a patient issue...then the first thing they say is was there the right amount of staffing, or did they have the right skill mix of competencies” (HRM, Hospital B)*. Staffing costs had to be balanced with patient safety considerations and shifts needed to be covered so that wards had necessary staff numbers to maintain patient safety standards.

Some permanent staff questioned management workforce planning practices and temporary staff use, especially with regards to the cost of temporary staff. There was recognition that for short-term illness absence, temporary staff serve a purpose in ensuring necessary staff levels for service delivery. However, the process of hiring temporary staff for long-term vacancies was questioned in terms of its cost-effectiveness in comparison to creating a permanent position. Management

decisions for using long-term temporary staff although necessary for service delivery, seemed contradictory to the wider systems issue of cost saving:

“Temporary staff are for sickness...but they seem to be using temporary staff to fill up employment vacancies, we have long-term temporary staff. I think they’re using them in the wrong context. If they have money to throw at temporary staff to fill that vacancy, they could fill it with a Band 5 nurse”
(Permanent 2, Hospital B).

The need to cover shifts so service provision was not compromised was a dominant theme among Clinical Managers and permanent staff at ED level in both hospitals. All staff discussed how rota gaps created difficulties in maintaining service provision, and the demand for service delivery necessitated adequate staffing levels. Put simply, *“We are short (of staff), we need somebody”* (Permanent 3, Hospital B). The Clinical Lead of ED (CL) in hospital B claimed the department would be difficult to run without temporary staff, as gaps in staffing makes patient care unsafe. Similarly, the Clinical Director (CD) in hospital A described temporary staff use as ‘need driven’ borne out of staff gaps (long-term and short term sickness, training, maternity leave and an inability to fill positions):

“It’s pretty much need driven, we all accept it’s not really a desirable path to go down...but we accept that the reality was we had lots of vacancies and you have to deal with it in a safe way” (CD Hospital A).

The Nature of the ED

The nature of the ED was discussed as an important factor for hiring temporary staff, being a 24 hour service with constant patient demands, staff are needed to cover vacancies to ensure that services can be safely delivered, with the Administrative

Service Manager stating: *“The service is a 24 hour service, it (the ED) is not going to close overnight, so we need bank staff to cover all eventualities”* (ASM, Hospital A). The Head of Nursing and the Matron at hospital B agreed that a 100 percent fill rate for vacancies was necessary, as when the workforce was thinly spread service delivery would be negatively affected.

EDs were viewed as a particularly challenging environment to work in. When a practitioner chooses their specialty, the ED may not be an attractive department for doctors and nurses: *“The shift pattern, the antisocial nature of the specialty and the stress...I think it’s not an attractive environment”* (Permanent 1, Hospital A). As a result, permanent staff indicated that some staff had left the specialty, with temporary staff used to cover the vacancies.

Departmental Satisfaction Levels

The Clinical Lead at hospital B described a local situation that resulted in a noticeable change in temporary staff use, in connection with poor job satisfaction feedback from the middle grades in the staff survey relating to their rota. To improve staff satisfaction scores, the regularity of shifts for middle grades had to be amended, *“Our middle grades used to be a one in two rota...so we have moved them all to a one in three rota, which meant that we had to deal with the gaps by using temporary staff”* (CL, Hospital B). Although rota changes improved staff satisfaction scores, and aided recruitment to the middle grade rota, this was negated by the resultant use of temporary staff, particularly at busy times (especially weekends) when staff numbers are reduced. Temporary staff were also used at hospital B because of local level performance indicators:

“Our performance has dropped off dramatically...we’re using a large number of locums just to try and boost up the numbers at vulnerable times... the senior managers have said because our performance is on a knife-edge for the quarter, to staff up the weekends and staff up the nights (we need to get temporary staff) (CL, Hospital B).

Local staff satisfaction and performance targets were important factors in the recruitment of temporary staff. However, it is unclear whether the reduced performance ratings were related to temporary staff use.

National External Factors

Temporary staff were necessary in the ED as a result of national external factors. A number of permanent staff mentioned how changes in the training of doctors meant that middle grade rotas were left inappropriately filled. Previously, in the transition from working as a SHO and applying to become a registrar, doctors from various specialties: *“Would often come to the Emergency Department as a relatively senior doctor and work on the middle grade rota. Now, because of the changes in our training, that no longer happens” (Permanent 1, Hospital A).* This resulted in situations where the number of trainees available did not match patient demands, with gaps filled by temporary staff.

As noted in Chapter 2, temporary agency employment legislation in the UK changed in October 2011 (during data collection), leading to equal entitlements and treatment for temporary agency staff after 12 weeks in the same role. The effects of this legislation could not be captured by the interviews, as respondents commented that they had not seen any figures relating to changes in temporary staff use. However, Clinical Managers voiced concerns about the practical impact this had on temporary

agency use – most notably, finding other ways to provide temporary cover if agency staff became too expensive. Additionally, EU regulations regarding who could work in the UK led to changes in the use of temporary staff as a result of the changes of access to work in the UK, leaving gaps in hospital rotas:

“We had a problem when the EU rules changed...We used to have a big pool of South African, Australian, Indian doctors, but when the EU rules changed, our pool of locums decreased dramatically...this made our middle grade level very, very difficult to recruit.” (CL, Hospital B)

The concern to meet nationally set targets for patient safety was also cited. As noted in Chapter 4, changes in Government targets for the ED occurred during the period of the study and even after the new quality indicators had been introduced, Clinical Managers and permanent staff still focussed on the need for timeliness of patient treatment. The knowledge that targets had to be met meant that when staff shortages arose, temporary staff were recruited:

“It is a supply and demand situation. There are targets to be met and patients to be seen, and not enough regular staff to do the job. Short-term contracts are just are a way of meeting these” (Permanent 3, Hospital A).

Hurst and Smith (2011) argued that temporary staff were more prevalent in London hospitals due to an increasingly mobile and casual workforce. Accordingly, the use of temporary staff was seen as the ‘norm’, a somewhat expected feature of the department. This was mentioned by the Head of Nursing (HN) in hospital B:

“We’re always going to need temporary staff, we’re a central London teaching hospital, staff go very quickly, the turnover is quick at lower grades.

We just have to accept that and that's a London thing, it's not unique to us."

(HN, Hospital B)

In summary, temporary staff were used in the EDs for a number of reasons. Those in workforce planning positions justified temporary staff use to allow for flexibility in vacancy levels to control fixed labour costs. However, those managing temporary staff at the department level, and those working alongside them discussed the need to use temporary staff to cover for a range of vacancies (e.g. sickness and maternity), ensuring adequate staffing levels, so performance standards could be maintained. The challenging nature of ED roles, partnered with external factors such as changes to training and EU staffing regulations led to staff vacancies, resulting in temporary staff recruitment. In terms of the most important factors for using temporary staff, there appeared to be differences between those in managerial positions and departmental clinicians. Workforce Managers discussed the flexibility temporary staff provided in an attempt to control labour costs, whereas for Clinical Managers, service provision and the need to maintain adequate staff levels so patient care was not compromised was key. Although the Workforce Manager at hospital B was concerned about the financial implications of using temporary staff (particularly agency staff), they recognised the safety dilemma that departments faced if understaffed, and the potential effects on patient safety and service quality if shifts remained unfilled. This highlights conflicting managerial priorities. If Workforce Managers worked towards 5-10 percent unfilled vacancies, then with the additional unavoidable absences, this implies an increased use of temporary staff, as Clinical Managers in the ED aimed to have 100 percent shift coverage, or having understaffed departments – both potentially negatively affecting patient safety and service quality.

5.4 Policies, Procedures and Practices in the Hiring of Temporary Staff

Results indicated that both hospitals had established policies, procedures and practices when hiring temporary staff. As mentioned in Chapter 4, hospital A and B used different temporary staffing recruitment approaches, with hospital A procuring the services of National Health Services Professionals (NHSP) (nursing and administrative and clerical positions) and hospital B used an internal staff bank based in HR. The decision making strategies and temporary staffing priorities used by the hospitals are presented from the perspectives of the three levels of staff interviewed.

NHSP was used at hospital A if they had an unfilled shift for nurses and administrative and clerical staff. If NHSP were unable to fill the vacancy, external temporary agencies were approached, however, this was organised in partnership with NHSP in accordance with agreed frameworks: *“You should be able to fill vacancies with permanent staff (overtime), if not then you should use NHSP or approved agencies to fill temporary positions”* (AWD, Hospital A). The NHSP Site Manager (NHSP SM) added that the NHSP booking system is electronically based. Shifts were filled in two ways. A ward could book temporary staff who they had previously worked with, developing familiarity with specific temporary staff. Alternatively, individual temporary employees could self-book the shift they wanted to cover.

NHSP uses both those already employed by the hospital (known as multi-post holders), and NHSP-only workers although the proportion of multi-post holders and NHSP-only staff was unknown. The NHSP site manager did perceive that: *“More of our shifts at (hospital A) are filled by their own staff (multi-post holders), but that*

doesn't mean that's all in the same ward...but they're familiar with the hospital"
(NHSP SM, Hospital A).

The Associate Workforce Director described attempts to improve the number of their own nursing staff signed up to NHSP, meaning that agencies would then only be used as a last resort. Attempts were made to reduce agency staff, due to the added financial costs of using them (however, he could give no indication about how successful they have been), although it was recognised that high agency costs resulted predominantly from using agency locums.

NHSP at hospital A did not recruit locum doctors, thus at a Clinical Managerial level, when the ED had doctor gaps, temporary agencies had to be used. The hospital had a contract with a particular external agency, although the Clinical Director admitted the agency had not always been able to provide adequate staff. The Clinical Director had to consider other agencies to enter into contractual agreements with, so a framework for appropriate temporary staff safety could be negotiated:

"The hospital has a limitation on which agency you can book from...the agency (the hospital) limits us to use wasn't delivering, as we can't close shop we have to go elsewhere...we had to find another arrangement" (CD, Hospital A).

There was a preference for locum agency staff who had worked with them previously, as the competencies of the individuals were known to the department. If regular locums were hired, they could be integrated into the team more readily and develop their clinical practice. This was one way in which risks when using temporary staff could be reduced:

“As they say, better the devil you know...those we know we can use their strengths appropriately in the way we distribute the workload. But those we don’t know, I suppose are a little bit more challenging” (CD, Hospital A).

The Associate Workforce Director recognised that some managers approached agencies outside of the agreed framework. When this occurred reminders were issued highlighting the agencies with the required framework agreements that should be used when recruiting temporary staff. Senior management had two main concerns relating to the recruitment of temporary staff: *“We need to know who it is who are supplying the staff, and then there is the cost” (AWD, Hospital A)*. The hospital needed assurances that the agencies vetted employees to the necessary standards and were following safe practice procedures (with regards to staff monitoring, CRB checks, mandatory training etc.) and that spending on agency staff did not rise above allocated budgets.

Hospital B had an internal staff bank incorporated into their HR department. When shifts remained unfilled, the hospital’s policy was to contact the internal staff bank to fill the position:

“Everything has to go via our staff bank department...they (wards) fill in a form saying the start and end dates and they have to give a position number to show it is an established funded position so that we can track it” (HRM, Hospital B)

The staff bank attempted to fill the position from those registered with them (the majority of which were staff who already work at the hospital), for two predominant reasons: cost (bank staff are cheaper in comparison to agency staff), and quality of service, *“You don’t have the quality issue because they (bank staff) are our own staff*

anyway” (HRM, Hospital B). If the internal staff bank was unable to fill the position, the staff bank then approached temporary agencies. However, the hospital had guidelines regarding agency use, with preferred suppliers and lists of approved agencies contacted in a hierarchical order (reaching the more expensive agencies towards the end of the list). The process described by the HR Manager was supported by the Internal Bank Temporary Staffing Manager (IBTSM):

“The first thing we’d do is we’d look to see if we could fill it by bank...if we can’t fill it by bank we would go out to agency, and for the agency we’d go to our first call agency, and if we can’t fill it with that we go to one of our other agencies” (IBTSM, Hospital B).

The HR Manager was keen to emphasise the importance of quality, and agencies had to be part of the patient safety agreed framework negotiated with the hospital, to manage the quality of agency staff used. The Internal Bank Temporary Staffing Manager added that if agencies did not comply with the framework agreement (and agencies were audited on a regular basis), they would be removed from the list. However, agencies were a last resort as a result of the increased cost of hiring agency staff in comparison to the staff bank.

The system described above was used for hiring nurses. For locums the procedure was slightly different. Locums were hired on fixed-term contracts (maximum time of 6 months), to reduce the costs associated with hiring locums on rolling contracts, as the hospital was aware that agency spend for locums was high.

At a Clinical Managerial level in the ED there were variations in how well the staffing protocols were implemented. The Head of Nursing and the ED Matron were clear about the hierarchy of temporary staff use, highlighting the importance of the

staff bank in the recruitment process. As with hospital A, at a clinical level, there was a clear preference for staff previously used as temporary cover:

“We’ve got some regular ones that we will be familiar with, and what their skill set is. If we have somebody that starts and has never been here before, not known to us, that is obviously on the hierarchy what we would really want to avoid” (ED M, Hospital B).

With locums, although it was recognised that the staff bank should be the first point of call and would be used if there was enough notice about the vacancy, temporary agencies were often relied upon. Approved agencies were used if the staff bank could not find anybody suitable, but, *“If they (staff bank and approved agencies) can’t fill it (staff vacancy), then we go to any agency we can find” (CL, Hospital B).* The Clinical Lead described a situation where waiting times were at an unacceptable level as a result of staff shortages, and so, *“I just phoned any agency I could find” (CL, Hospital B).* The department had a list of locums who had previously covered shifts, and these individuals were contacted as known locums, having knowledge of the hospital environment and patient protocols. When patient demand exceeded consultant staffing, the Clinical Lead conceded with regards to decision hierarchies and preferences: *“We prefer people who can fill the gaps, and we have a particular problem with filling the gaps that we have, so whoever can fill them, those are our preferred suppliers” (CL, Hospital B).*

Both the HR Manager and the Internal Bank Temporary Staff Manager discussed a particular issue concerning locum staffing in the ED - the department had been bypassing the staff bank and using external agencies not approved by the hospital’s framework agreement, noting concerns particularly regarding the cost, *“In this*

hospital, we do not use non-framework agencies...(the agency) was really expensive, much more expensive than other agencies” (IBTSM, Hospital B). Initiatives were introduced through which the staff bank must be used, with ED staff encouraged to sign up to the staff bank with the knowledge that the staff bank was the first point of call for temporary staff (thus increasing the likelihood of their use). For cost saving initiatives this had been helpful. However, at ED level, temporary cover remained problematic:

“Because there is a big pressure for us not to use agencies because they are more expensive, it leads to a downside that we cannot fill the gaps usually filled by the agency” (CL, Hospital B).

Permanent staff working alongside temporary employees (in both hospitals) showed a distinct preference for temporary staff who had worked in the department before, as their skills would be known and they could be integrated into teams. Permanent staff felt more comfortable working alongside regular temporary staff, as they were considered safer, more reliable and required less supervision in comparison to ad-hoc temporary cover. The specialised nature of the ED was highlighted when discussing the preference for internal bank staff or those who knew the hospital, as permanent staff had more confidence in their ability to provide timely and accurate patient care. As a result the EDs kept lists of the temporary staff they used and trusted, who were prioritised when needed.

It was not always possible to hire ‘known’ temporary staff, and ad-hoc hiring was common. Permanent staff acknowledged that, *“Bank and agency staff get a raw deal in the fact that people don’t know what they have done before” (Permanent 3, Hospital B)*, and they should not be discarded as a result, adding that management

have to adapt how temporary staff are best managed to ensure suitable patient care. This echoed the Head of Nursing at hospital B, who stated that in most cases it was better to have temporary staff than no staff, but: *“You have to develop a relationship with them as they become your critical friends” (HN, Hospital B).*

In summary, both hospitals had policies for hiring temporary staff. Although they used different procedures for the procurement of temporary staff (hospital A using NHSP (for nursing and administrative and clerical staff) and hospital B using their internal staff bank), if temporary staff were needed, Clinical Managers were encouraged to use staff banks as this was cheaper (and perceived to be safer) in comparison to external agencies. At hospital B agencies were a last resort, and had to be part of the hospital framework agreement (although there were occasions where this was ignored). At hospital A, locums were hired through agencies as NHSP did not provide them. What was unknown was how often managers were successful in recruiting from the staff banks and the extent to which agency staff were relied upon.

At clinical levels, although it was acknowledged that agency staff should only be used as a last resort, for locums (at both hospitals) agency staff were often used as staff were needed for patient care provision. For Clinical Managers and permanent staff, there was a preference for temporary staff known to the ED, as they would have knowledge of their skill set and having regular returnees provided the opportunity to develop a relationship with them. This suggested that limited familiarity both with the working environment and the team could create risks for patient safety and service quality that managers had to attempt to avoid.

Although hospital A used NHSP for the procurement of temporary staff (nurses and administrative and clerical), the policies, procedures and preferences for hiring of

temporary staff were similar to that of hospital B. The difference between the two hospitals was clear when hiring locum staff – with hospital A solely using agencies, whereas hospital B approached the staff bank first, although agency staff were still relied upon when shifts remained unfilled. Thus, both hospitals had policies, preferences and practices for hiring temporary staff, however, the practices sometimes went against the policies when it conflicted with the need for ‘bodies’ to fill gaps to maintain patient safety.

5.5 Clinical Evidence of Temporary Staff Risk to Patient Safety

As reported in Chapter 3, quantifying the risks of temporary staff for patient safety and service quality has been difficult partly because the extent and nature of the temporary population is unknown. The ability (or lack of) to quantify such risks was a theme that emerged from the data.

The Executive Directors at both hospitals, although concerned with patient safety outcomes as a quality indicator, indicated that patient safety issues were of greater concern to the Clinical Managers. When questioned regarding evidence for increased risks or reduced patient quality when using temporary staff, both hospitals were unable to provide evidence to show this occurred. Hospital A’s Associate Workforce Director reported that complaints about patient care when using temporary staff were no greater compared to permanent staff, whereas their counterpart at hospital B stated:

“I don’t think we could pull any data that says that the quality of permanent staff is better than that of temporary, we can only say this ward gets better ratings for patient quality than that one and look at fill rates...You could

make assumptions based on fill rates and patient quality ratings, but these would not be very scientific.” (HRM, Hospital B)

Although both hospitals conduct various surveys about patient experience, the Executive Directors highlighted the lack of clarity when attempting to relate patient experience and safety to temporary staff use.

The NHSP representatives at hospital A discussed the challenges of overcoming typical stereotypes regarding temporary staff and patient safety. The CEO of NHSP discussed the conventional wisdom that temporary staff equates to unsafe care, and this was the PR challenge that NHSP faced. However, NHSP believed that if managed properly, then the message of safe temporary staff use could be portrayed. By focussing on using local bank staff, known to the hospital and known to be reliable, there was an increased likelihood of safer patient care. This was qualified when they stated:

“Our data says that when there are agency staff we have higher levels of complaints... if I try and interpret that, that’s because agency (staff) tend to be more short notice in hospitals....so the issues that you get around continuity and reliability, there’s going to be a high propensity of that through agency...” (CEO NHSP, Hospital A).

It could be inferred that to ensure patient safety and service quality when using temporary staff, implementing a risk management strategy that aids re-hiring known staff to vacant shifts, reducing the need for ad-hoc agency staff, would be beneficial. This was an aim of NHSP – to construct and maintain a staff bank to retain temporary staff to minimise complaints regarding reliability and continuity associated with their use. The NHSP representative at hospital A also argued that

there was a traditional ‘misconception’ that temporary workers under-perform (affecting service quality), and any risks associated with temporary staff were very much determined by the individual.

At hospital B, the Internal Bank Temporary Staffing Manager reported that the bank did not receive incident rates, but when a complaint was made about a bank or agency worker, this was reported in the same manner as permanent staff complaints, and all complaints were investigated. However, in line with the HR Manager, the Bank Manager reported that there were no statistics about the level of incident rates and the use of temporary staff in relation to patient safety and service quality. The Bank Manager recognised that even if statistics indicating that temporary staff led to poorer patient safety existed, other systems factors would also have to be considered: *“It would all depend on the proportion of temporary staff and how much control you have over them” (IBTSM, Hospital B)*. Consequently, any statistics indicating that using temporary staff leads to greater patient safety risks have to be questioned in the light of other factors that influence patient care, and not solely focus on the temporary employee.

At departmental level, the Clinical Director of the ED at hospital A stated that when using locums there was always the assumption that their quality of care would be lower than permanent staff. The department had a weekly meeting where adverse incidents were reviewed and monitored, and although it was recognised that serious untoward incidents do not occur very often:

“Experience would tell us, that near misses, a significant proportion of them have involved locums both in patient safety and patient experience terms. So

on the whole there's a clear link between agency and poor patient experience and poor, potentially poor outcomes" (CD, Hospital A).

However, the department could not provide any statistical evidence suggesting that this was the case, and when probed about the nature of the complaints, locums were described as being involved 'directly or indirectly'. A critical incident was described when a temporary employee did not fully question the referral of a patient, which ultimately led to the patient dying. However, the interviewee questioned whether the temporary employee was solely to blame, as the role of indirect factors such as it being a night shift, the limited systems awareness and the departmental culture regarding the appropriateness to question or to challenge decisions also needed to be considered. This clearly highlighted the complexities of attempting to correlate temporary staff use with patient safety and service quality and indicates that risk management initiatives put in place should not solely focus on the temporary staff, but on the systems they work in.

The Clinical Managers at hospital B, echoed the response provided by their HR Manager, confirming there were no direct statistics indicating that when temporary staff were present then patient incidents increased proportionally. However, they did concede that it became more difficult to run the department, as patient care could be slower and as a result, service quality could be affected. Instead of assuming that temporary staff provided a lower standard of patient safety, it was recognised that as their training and qualifications had been checked before entering the department, and as they were still registered practitioners, a baseline of patient care should be maintained. Consequently, the use of temporary staff for patient safety was not considered by one of the participants to be a significant practical problem, "*We don't have a huge number of complaints around poor care and...it is not as big a deal as*

you would imagine it to be” (HN, Hospital B). The Head of Nursing suggested that temporary staff could be of greater risk to service quality, taking longer to dispatch patients as a result of not understanding the finer details of the admissions process, and argued that service quality would be better with a constant workforce. However, it was acknowledged that if service quality was reduced then it would be unfair to attribute everything to temporary staff, highlighting the need to consider the role of other factors that contribute to patient safety and service quality outcomes.

The difficulty in quantifying the risks of temporary staff for patient safety and service quality was discussed by permanent staff: *“I think it is very difficult to quantify, but I think, I feel there is a relationship, direct relationship between the amount of casual staff and probable clinical incidences in patient care” (Permanent 1, Hospital A).* However, the measure of patient risk was also thought to be proportional to the number of temporary staff in the department, as this would affect the level of support temporary staff received (once again highlighting indirect factors).

The responses from permanent staff who highlighted a dimension that was unexplored by managers – the level of patient safety and service quality provided by temporary staff was based on the individual temporary employee, consequently any generalizations surrounding temporary staff and patient outcomes were unfair. When patient care was perceived to have been affected by temporary staff, this was typically associated with agency staff, but once again, this was person specific, dependent on the area of the ED they were working in and if they had previously worked in the department:

“(Impact on patient safety) varies, because their skills vary...I am not saying that every agency member of staff is rubbish, I’m just saying you’ve got the odd one that slips through...I think it depends where you work and who you get” (Permanent 2, Hospital B).

The idea that temporary staff would risk patient safety as a result of their clinical competence was discussed by some permanent staff. One reasoned that as the clinical competency checks are conducted by the hospital (hospital B), they would have the baseline skills to provide necessary care, but other factors such as familiarity with the environment, could theoretically lead to reduced patient safety. However, the issue of clinical competency should not be limited to temporary staff: *“There can be a clinical competence issue for a sub-group of people (temporary staff), but the percentage of temporary staff with a competence issue is probably the same as permanent staff with a competence issue” (Permanent 6, Hospital A).*

In summary, the perception that using temporary staff would lead to greater risks to patient safety and service quality was not supported by systematic clinical evidence. What was prevalent, was the common perception that temporary staff resulted in unsafe patient care, confirmed by the Clinical Director at hospital A, who although unable to provide statistical evidence, claimed there was a clear link between agency staff and poor patient experience.

Staff at both hospitals inferred a difficulty in separating the role of temporary employees and other factors that could influence patient care. Similarly staff at hospital B discussed the relationship between the proportion of temporary to permanent staff during shifts, and constraints on the level of supervision of temporary staff. Clinical Managers at hospital B recognised a dichotomy between an

actual risk (reduced if appropriate temporary staff were hired and other risk management strategies were implemented), and the theoretical risk. Hospital B's ED staff expected a certain baseline of care from temporary staff which they believed temporary staff could provide, as they required temporary staff to have up-to-date mandatory training, whereas the Clinical Director at hospital A began with the expectation that the quality of care from temporary staff would be low. The lack of evidence collected by both hospitals does create a problem, as this feeds perceptions regarding a poorer standard of care provided by temporary staff.

5.6 Factors Leading to Risks to Patient Safety and Service Quality when using Temporary Staff

In Chapter 3 ways in which temporary staff could present a risk to patient safety and service quality were identified. The participants in this study described factors that could lead to potential patient safety and service quality risks when using temporary staff in EDs, and ways in which these risks could be best managed. Some critical incidents were provided, highlighting risks associated with temporary staff.

Familiarity with the Emergency Department

Clinical Managers and permanent staff from both hospitals had a distinct preference for individuals who had knowledge of the specific ED (either their own staff working through the staff bank, or a known external temporary employee), perceiving them to provide a higher standard of patient safety and service quality in comparison to those employed ad-hoc. It was reported that those with previous knowledge of the department would have greater local awareness of the physical environment resulting in patient care not being compromised or delayed:

“Half the time they (locums) look and feel lost...that tends to influence how they behave...this is why we favour locums who work with us consistently. The real risk with locum staff is that because their awareness of the system is limited, the quality of their clinical practice may not be quite the same (as permanent staff).” (CD, Hospital A)

Permanent staff provided a range of factors explaining why unfamiliarity with the department could delay patient care, including not knowing where the emergency equipment was kept (resulting in more time spent undertaking basic tasks) and temporary staff not being issued with staff log-ons, computer passwords or codes to access equipment or medication (leading to delays in ordering necessary tests, finding patient records or test results and delays in administering medication). This was of particular relevance in the ED as emergency care is time critical and slowing this process could have implications for patient outcomes:

“How familiar they are with the surroundings will impact the care of patients because it just delays the process when they don’t know where things are kept, where to find things, what to look for, what to do with the patient. When they don’t know the other information relevant for patient care, then the whole delay in process will impact on patient care” (Permanent 4, Hospital A)

The Clinical Director in hospital A acknowledged that although the temporary staff hired had the necessary qualifications, the limited systems awareness would impact their service quality. Using ad-hoc temporary staff could result in higher complaints and adverse incidents. His counterpart at hospital B described this as a theoretical risk, but if left unmanaged could develop into clinical risks. The Clinical Lead

explained that although limited environmental awareness could lead to risks to patient safety, measures had been implemented to reduce them, including induction and increased supervision. The Head of Nursing at hospital B argued that theoretically patient safety should not be compromised as temporary staff were required to have a baseline of ED skills, but the limited geographical knowledge of the department had greater implications for service quality:

“It should not have an adverse effect on care, as care is care regardless of where you are. Where they may be slightly compromised is not knowing where certain wards are, so it is not knowing the geography of the place, rather than the giving of physical care” (HN, Hospital B).

Permanent staff at hospital A, stated that in many cases environmental issues rather than competency played a bigger role in the smooth running of EDs when using temporary staff. Permanent staff had to spend more time helping temporary staff, reducing the time available for experienced staff to deliver patient care, affecting patient experience and service quality.

In comparison, permanent staff undertaking occasional temporary shifts, and regular ED temporary staff were perceived by Clinical Managers and permanent staff in both hospitals to be comfortable in the environment, able to function independently, and have knowledge of the local guidelines and departmental protocols: *“Our own staff will know the practices and procedures, flow of patients and where everything is. That is the advantage of using own staff to do bank as a preference” (ED M, Hospital B).*

As risks to patient safety and service quality resulting from limited environmental familiarity had been recognised, measures to minimise risks were discussed – based

around two main initiatives – the use of regular temporary staff, and the staff induction.

NHSP at hospital A was keen to highlight the importance of using multi-post holders, or the same temporary staff to minimise risks to patient safety. They mentioned that nationally 83 percent of NHSP staff worked multiple shifts in the same ward over a period of 3 months, and only 7 percent of shifts were completed by a temporary member of staff working in a ward for the first time. At a local level, the NHSP Site Manager could not provide any figures relating to the number of staff who re-book shifts in the ED, but stated, *“more shifts are being filled by people who know the wards and the hospital...there is a preference for those to work in wards that they are familiar in”* (NHSP, SM, Hospital A). In hospital B, the Bank Manager (who was unable to provide statistics detailing the number of regular returners) mentioned the majority of those signed up to the staff bank were the hospital’s own staff, consequently risks as a result of environment unfamiliarity were limited, as the staff bank was prioritised for covering vacancies.

Permanent staff had very little to do with the management of hiring temporary staff and could comment very little on this. However, they did acknowledge the importance of hiring familiar staff. If new temporary staff were used there was the understanding that, *“You cannot expect them (temporary staff) to know everything straight away”* (Permanent 3, Hospital A). This highlighted the importance of another risk management strategy used in EDs – the role of induction – and how this could be effectively implemented.

Staff at all levels recognised the importance of induction, although there were variations between the two hospitals regarding what should be included, and whether

inductions were completed. The Executive Directors at both hospitals explained that templates existed indicating what was necessary to include in inductions, but conceded that inductions could be accelerated, especially when the ED was busy. In both hospitals, the type of induction received was dependent on length of contract, with temporary staff on fixed-term contracts receiving a corporate induction.

Hospital A had recently been inspected by the Care Quality Commission who checked the induction and the Associate Director for Workforce was confident in the hospital's provision of inductions for temporary staff. At hospital B, although it was acknowledged that if temporary staff were not provided with an induction, quality could reduce, reservations were expressed about the compliance of their provision: *"Whether we're compliant on that a hundred percent is slightly different, but they are meant to get some level of local induction..."* (HRM, Hospital B). The staff banks at both hospitals recognised that it was the ward's responsibility to provide the local induction. Temporary staff at hospital B were informed they were to receive an induction and confirm to the staff bank that this had occurred. In a recent audit conducted by the staff bank, 90 percent of temporary staff bookings reported receiving an induction. There were no explanations why 10 percent of temporary staff had not received it.

At departmental level in hospital A, very little was mentioned about the induction from Clinical Managers, apart from the notion that the induction needed fine-tuning so, *"At least they get something when they (temporary staff) arrive"* (CD, Hospital A). Clinical managers in hospital B provided some indication about why not all temporary staff received an induction, as those hired ad-hoc enter an already busy and understaffed department, meaning inductions were increasingly difficult to deliver.

For both locums and temporary nurses the basic induction included local guidelines, the provision of uniforms, and knowledge of how equipment in the department worked (acknowledging that basics should be provided in time limited situations). The Matron (hospital B) added that temporary nurses should attend the staff handover so they knew the key staff contacts for the shift, and there was the expectation they would then be shown around the department, and the induction provided an opportunity to not only improve environmental familiarity, but to discuss the department's expectations regarding the role of the temporary employee:

“They need to be given a very clear induction...showing them around, showing the equipment, restricting their duties and making it absolutely clear to them what their expectations are, making it clear to them what they can and cannot do...that's clear boundaries of how we can manage that risk”
(ED M, Hospital B).

Temporary staff induction as a risk management initiative was evident among permanent staff at both hospitals, acknowledging its importance in relation to the ED geography and physical location of items. The permanent staff at hospital B echoed their Clinical Managers, discussing the induction's importance in clarifying roles that temporary staff would be expected to undertake and determining what ED experience the temporary employee has had, developing an understanding of their competencies and gauging what could be expected from them. Any risks associated with lack of clinical knowledge could then be managed accordingly:

“...It gives you an idea of what they've done before, what skills they've got, what you can ask them to do, what you can't ask them to do...the key information is how the department works...if people aren't inducted they

don't know how the department works, what our expectations are"
(Permanent 3, Hospital B).

In summary, limited knowledge of the physical environment had implications for patient safety and service quality, and could lead to delays in patient care when looking for, and learning to use equipment and learning the relevant specifics of ED patient guidelines. To reduce these risks, both hospitals acknowledged the importance of using their own bank staff or regular temporary staff and the role of induction. Clinical managers at hospital B reported that the induction should also include role expectations for the temporary staff and the opportunity to verify the level of ED experience the temporary employee has, so they can be designated specific tasks and appropriately managed, minimising risks. The nature of the ED was cited as a possible reason why inductions were not provided even though service delivery would improve if there was a greater understanding of the environment in which temporary staff operated.

Team Familiarity and Stability

Interviews, especially with clinical managers and permanent staff highlighted how familiarity and stability could be affected by temporary staff, and the implications for patient safety and service quality. The Clinical Director in hospital A spoke of the importance of maintaining team cohesiveness and having strong teams, particularly in the ED, as teams were heavily relied upon as a method of reducing patient errors. As with environment familiarity, temporary staff known to the department were preferred: *"We want to integrate them into the team, which is why we favour locums who work with us consistently"* (CD, Hospital A). Temporary staff unknown to the department could challenge team stability and chemistry:

“Those we don’t know can be a little more challenging...someone who is rigid and who does not really align with the philosophy of the department can cause an enormous amount of stress...that’s always the risk with new and unknown locums.” (CD, Hospital A)

The risks with team familiarity and unknown temporary staff were closely connected to problems with communication and engagement with other team members. Those unknown to the department were perceived to gravitate away from the team, and even though they were clinically competent the Clinical Director provided examples of locums who felt unable to challenge decisions that other staff members had made, *“Locums may not have the confidence to challenge or the confidence to speak to senior staff which then adds to the risk...if they feel they don’t belong...if they feel unsupported, that tends to influence how they behave” (CD, Hospital A)*. Patient safety and service quality had the potential to be compromised when patient care decisions went unchallenged when there was a more appropriate course of action.

Although team stability was important, it was recognised that temporary staff had become a critical feature of the ED. The Head of Nursing at hospital B described team instability as a common feature of the ED as a result of the range of staff the ED had contact with. Consequently, instability did not just result from the ‘traditional’ notion of temporary staff. The definition of temporary staffing was then further blurred:

“They (staff) accept that it’s the norm that people come in as temporary staff. The thing about ED and temporary staffing is it’s not just temporary doctors and nurses. Every day they’re seeing temporary staffing as much as the medical teams coming in, the surgical teams coming in, other professionals

coming in...therefore the whole department runs on an element of unknown staff” (HN, Hospital B).

The risks to patient safety and service quality as a result of temporary staff and team familiarity were discussed in hospital B, in relation to the development of patient pathways and procedures, which became more difficult to implement with ad-hoc staff. However, this was considered to be more of a theoretical risk, as measures had been implemented to attempt to manage risks to patient safety that limited team familiarity and team stability could cause.

The Clinical Lead at hospital B accepted that unknown locum staff may need extra supervision. However, ED staff discussed a culture of supervision for all staff as a result of changes in national training and the reduction in experience of permanent staff. Consequently locum use did not greatly change the levels of supervision given to staff. The internal staff bank was highlighted as a method of improving team familiarity and stability, with the increased opportunity to re-book those who had worked with them previously or their own staff working extra shifts. As a result of an ED culture used to the presence of temporary staff, the managers assumed that there was a tolerance amongst staff regarding the supervision of temporary staff aiding team stability and familiarity, and minimising associated risks.

The role of team leadership in managing team stability was highlighted by the ED Matron at hospital B, who emphasised the importance of meeting and welcoming temporary employees when they arrived, the need to clarify what was expected of them, and the need to allocate temporary staff to teams in which they would be closely supervised: *“We do our best to make the temps feel welcome...to make sure that they are supervised and supported through the shift and what we expect of*

them” (ED M, Hospital B). Communication between temporary and permanent staff was encouraged by Clinical Managers in an attempt to reduce any barriers between team members that could risk patient care.

The importance of team familiarity was evident among the permanent staff in both hospitals. One theme often discussed was being able to trust the temporary employee, in relation to their attitude towards achieving the team goals, reliably identifying any patient issues and performing safely in the ED. The level of trust in temporary staff was related to the frequency or regularity of their shifts:

“If you are employed by (the hospital), you have a team player attitude, working towards making sure the patient is safe...if they are regular then you are happy to have them in the team...those who are here now and again, you are not very confident in them.” (Permanent 4, Hospital A)

Permanent staff indicated that it was important to quickly establish channels of communication with temporary staff, so if an incident did occur they would know who to approach to minimise delays in patient care. When temporary staff were not integrated into the team, permanent staff reported poor communication, risking patient care: *“If they don’t quite know anything, they’re struggling and they just carry on with what they are doing, it can definitely impact the patient...with poor communication things fall apart” (Permanent 2, Hospital B).*

With clear communication channels within the team, a safety culture developed, with permanent staff reporting that temporary staff approached them with any difficulties, and there was clarity about the expectations of temporary staff. These channels of communication were developed through regular working within the department and through time being invested by the permanent staff, welcoming temporary

employees into the team. This provided some evidence of an exchange relationship between temporary and permanent staff. If permanent staff welcomed temporary employees to the team, in return temporary staff would be willing to engage with the team:

“If you invest a little bit of time at the beginning and they feel they can come to you, you’re probably going to get better work...providing that you make them feel welcome and then you project yourself as someone that they can come to if they’re not sure how something works” (Permanent 1, Hospital A).

Some permanent staff discussed language barriers with temporary staff from different cultural backgrounds. Harris, Ooms, Grant et al., (2012) highlighted that for many years nurses from a range of ethnic groups have contributed to the nursing workforce, as well as an increase met by overseas recruitment. On occasions, such temporary staff had struggled in the ED as a result of language issues and the inability to clearly communicate what they needed, potentially compromising patient safety and service quality as a result of differences in the way that care is approached and how policies and practices are communicated across the team. The Clinical Director at hospital A had identified barriers in communication with regards to cultural differences and developed a cultural development programme, recognising some of the frustrations that doctors from overseas may face when entering the NHS. However, this was not applied to temporary staff, even though communication barriers and cultural differences were discussed as factors influencing team stability.

The nature of the ED was considered as a factor influencing how well temporary staff were integrated into the team. The ED is a fast flowing environment, with targets in patient care to meet, and consequently: *“In the busier places, locums might*

well be left to sink or swim a bit...in a busy, busy shift, certain things can slip through the cracks” (Permanent 2, Hospital A). Even though the Clinical Managers attempted to employ regular temporary staff, and (especially in hospital B) foster a culture where team supervision is the norm, the nature of ED and the focus on timeliness of patient care could affect how well temporary staff are integrated.

In summary, integrating temporary staff into the ED was seen as important for managing and minimising risks to patient safety and service quality associated with their use, as this allowed for the development of communication channels between temporary and permanent staff. When employees were integrated into the team, staff began to trust each other in the roles they were undertaking. Both hospitals had measures in place to develop team familiarity and provide team stability. There was a distinct preference for regular temporary staff who permanent staff could develop a trusting relationship with and understand their strengths and weaknesses. Clinical Managers at hospital B described a culture of tolerance and supervision of temporary staff, which meant they would not be left alone when entering the ED, and part of the induction was to ascertain what skills the temporary employee had so they could be integrated into the team accordingly. The role of leadership was also emphasised by managers in hospital B, welcoming and clarifying the expectations of temporary staff in an attempt to develop employment relationships and channels of communication. Evidence of exchange relationships were seen, with the perception that time spent integrating the temporary employee would lead to improved performance from temporary staff in return, as well as developing trust in their performance.

However, a number of barriers to team familiarity, stability and integration were identified. Communication between team members was difficult if there were language or cultural differences. The nature of the ED, providing swift service

delivery meant that supervision of temporary staff became limited during busy shifts. having implications for patient safety, and especially service quality.

Training and Development

In Chapter 2, an argument discussed for using temporary staff was the reduced financial costs resulting from not providing training (especially if the return would be less than the original cost of the training) (Wiens-Tuers and Hill, 2002). The training of temporary staff was a theme discussed by participants as a factor that could affect patient safety and service quality, especially if those hired were inappropriately trained for the role.

The role of personal development (performance feedback and appraisals) for temporary staff was recognised as important for risk management. Previous research found that temporary agency workers had reported that they did not receive performance feedback or evaluations that could be used to guide future and corrective behaviours (Gossett, 2006) resulting in mistakes or limited productivity going undetected. The implications of this for patient safety and service quality were discussed, as well as how this could be managed in the ED.

The NHSP site manager at hospital A highlighted the limited training opportunities for temporary staff – especially ‘bank-only’ staff (those working for the bank but not employed by the hospital), as temporary staff were not offered the training opportunities provided for permanent staff. When training was offered, temporary staff were expected to attend it in their own time, limiting their opportunity for earning, or supplementing their income, and it was questioned whether temporary staff attended it. In an attempt to overcome training discrepancies between permanent and temporary staff, NHSP provided an e-learning training platform for

the bank-only workers (permanent workers had this provided to them through the hospital) including all mandatory training courses, and a biannual practical session, where what was learnt through theory was displayed in practical assessments: *“Our mandatory training modules are basic life support, moving, handling, health and safety, infection control, fire awareness, safeguarding adults and children, and then data protection.”* (NHSP SM, Hospital A). The NHSP CEO stated that the regulatory checks conducted on all NHSP applications in relation to CRBs, occupational health and mandatory training should allay fears that using temporary staff results in unsafe care. If temporary staff had not completed their training and were deemed unsafe for practice, they were deleted from the NHSP register, minimising risks to patient safety and service quality at that particular hospital.

Similarly, in hospital B, the internal staff bank had policies relating to the training of temporary staff. Temporary staff who were bank-only (they did not know the proportion of staff affected) had mandatory training provided for them, however, as with hospital A they were not paid to undertake it and had to complete it in their own time. However, the training provided was free of charge. The internal staff bank made their mandatory training policy clear for any potential temporary employees:

“We have a system whereby if they haven’t done it and they’re not up to date and they haven’t done their moving and handling or whatever, then they will get blocked on our system and they wouldn’t be able to do any more work”
(IBTSM, Hospital B).

The staff bank provided an incentive to encourage (especially bank-only) temporary staff to complete their training, and simultaneously manage risks associated with inappropriate training. Temporary staff were eligible for recruitment only when

training had been completed. Hospital B also employed a senior nurse facilitator to ensure the bank-only staff completed mandatory training. However, the Bank Manager added that medical professionals have a code of conduct that they work by, through which they have a responsibility to keep themselves up to date with their training, theoretically reducing risks to patient safety and service quality as a result.

The Bank Manager at hospital B also discussed monitoring temporary staff training when outside agencies were used. Temporary agencies used by the hospital were audited regularly to ensure they conducted mandatory training checks. With regards to how this filtered down to ED specific skills, a worker checklist was developed to ensure agencies provided temporary staff appropriate for the role. The management of the staff bank with regards to training checks was considered comprehensive:

“One of the things we do is the whole thing about the agency working placement checklist, absolutely making sure that every single worker has been checked out, so it is very unusual that we would find somebody that had worked here who didn’t have the skills or the qualifications” (IBTSM, Hospital B).

The benefit of having an internal bank was highlighted, as the staff who worked there were described as having a sense of ownership over their role in delivering the best temporary staff for the hospital, in comparison to outside providers who would be working with a number of hospitals. Consequently, the provision of staff not sufficiently trained for the ED was minimised in hospital B through stringent monitoring of temporary staff, and their method of procurement.

At a Clinical Managerial level in hospital B, there was the assumption that training checks were conducted through the staff bank and agencies. Managers relied on the

staff bank to only send through the CV's of staff with up-to-date training and relevant skills. If the checks had been conducted appropriately, it was suggested that temporary staff would not be a risk to patient safety and service quality:

“There’s an assumption that people are all registered nurses, therefore are able to work to a certain level...checks are done through the agency and through the bank, so we can assume that those checks have taken place”
(HN, Hospital B).

The hospital also assessed some skills when the temporary employee arrived in the department (nurses specifically) to test their competence levels, so clinical managers and permanent staff knew the level of skill the temporary employee had, so they could organise necessary supervision. The Matron suggested that the management of training and CRB regulations could be tightened, with the development of a national skill set, so that courses would teach standardised skills. This national skill set would ideally mean that wherever temporary staff had worked or undertaken training previously, hospitals would know the skills taught, consequently managers would be increasingly assured that temporary staff were appropriately trained. The issues regarding training highlighted the preference to use bank staff known to the department as the Clinical Managers would know what training had been completed, meaning that patient care roles were co-ordinated more effectively: *“Using our own (bank) staff gives us the great advantage in that we know them, we know their skills and what their training level is. It gives us that assurance”* (ED M, Hospital B).

In hospital A, the Administrative Service Manager discussed NHSP and their provision of temporary staff, reporting that some temporary staff recruited through NHSP did not have the same level of training in comparison to their internal pool of

temporary staff – seemingly contradicting the positive views expressed by NHSP’s CEO. This resulted in the need to provide further in-house training, adding further pressure on the permanent staff having to address any problems with the accuracy of the tasks completed. As with hospital B, this highlighted the preference for using internal staff:

“We prefer to use our own staff because we know they have the skills and competency to carry out the role. NHSP staff will not be up to the same standards as our own staff (multi-post holders) because they have not had the same training” (ASM, Hospital A).

The Clinical Director at Hospital A recognised that locums (even those on long-term locum contracts) did not receive the same training as permanent staff. In an attempt to manage training whilst in the department, locums had a named consultant to provide on-the-job support. Due to budget constraints, the ED was unable to sponsor individuals if they required a paid training course. However, the clinical director added that: *“We are interested in getting people for substantive (posts) so we can develop them” (CD, Hospital A).* This provides some support for the financial flexibility argument outlined in Chapter 2. Permanent staff received training as long as they remained in the organization and the outputs were beneficial for the organization. This training was only offered to temporary employees if they accepted a substantive position in the ED – thus when they were no longer temporary.

Permanent staff at both hospitals stated that it was the agencies or the staff banks role to provide the necessary training for temporary staff, and to ensure that any staff assigned to the departments had their mandatory training. Permanent staff at

hospital A acknowledged that staff who apply for temporary work must still be registered practitioners, and consequently maintain their regulatory standards. Permanent staff at hospital B acknowledged that although training checks should have been undertaken, training and competency had to be double checked on arrival and this was a method adopted by the hospital in an attempt to reduce any risks to patient safety and service quality.

In terms of professional development for temporary staff, respondents from both hospitals indicated that providing feedback to temporary staff was difficult, if not impossible, due to the time this would take, and the number of temporary employees the EDs used:

“They do not have appraisals because we don’t have the time and facilities to do it. One thing I think you have to understand is the sheer scale of it, it’s enormous. In this hospital we have 7,000 registered on the bank” (IBTSM, Hospital B).

As a result of the scale of temporary staff use (the proportion of permanent staff registered with the bank was not revealed), the bank manager admitted that in terms of appraisals and professional development, temporary staff were treated differently to permanent staff. The staff bank investigated any reports regarding the performance of temporary staff, but the level of feedback to the temporary employee regarding best practice and how to correct behaviour was uncertain. The bank manager conceded that performance feedback was predominantly based upon being re-hired – if temporary staff worked well, this increased their likelihood of being asked back. This could have a negative effect on patient safety and service quality, especially if temporary staff do not receive the opportunity to learn how to rectify

behaviours. The bank manager added that at hospital B, multi-post holders were part of an appraisal system (being permanent staff), receiving feedback and opportunities for personal development, limiting risks to patient safety and service quality.

Clinical Managers at both hospitals made a distinction between formal and informal feedback given to temporary staff, stating that the typical feedback received by temporary staff was whether they would be booked again dependent on their performance: *“So the feedback is generally we re-book them” (HN, Hospital B)*. In hospital A, regular locums, and those hired on fixed-term contracts received some support and feedback, especially if they performed well, in an attempt to encourage them to become permanent members of staff when a vacancy arose. Long-term locums received the support of a named supervisor, providing informal feedback during the locum period, especially when there was a persistent weakness in practice. Difficulties arose providing feedback to ad-hoc agency temporary staff, due to the fast-pace of the ED. If an incident occurred involving agency staff, the easiest form of feedback was to not hire them again. Although this minimises risks to patient safety and service quality in this specific ED, if the behaviour was not corrected, or the temporary staff do not understand their mistake, similar incidences could occur in other hospitals the temporary employee may be appointed to. This concern regarding agency staff (who may only be hired for one shift) and managing their development was discussed in detail by the Matron in hospital B. As the agency officially ‘manages’ the employee, the difficulty in gaining statements, addressing improvement and appropriately managing the agency employee became difficult:

“How do I contact them? How can their practice be addressed, in terms of what went wrong, what they need to improve on in their practice? I don’t get the assurances that when I raise things like medication incidents to an

agency that it is then appropriately managed. It does make risk management more challenging.” (ED M, Hospital B)

In an attempt to manage risks associated with feedback to temporary staff, the Head of Nursing at hospital B reported that general feedback was provided to all staff (permanent and temporary) throughout the shift, with a specific nurse-in-charge ensuring that patient care was delivered safely. This culture of supervision was considered important to check that temporary staff understood what they were expected to deliver, that patient care was completed to the necessary standards and if risks were identified, they would be rectified. Although, it was recognised that this was not as comprehensive as ‘formal feedback’, having a culture where supervision and feedback were provided as second nature could help mitigate risks to patient care.

How feedback (or lack of it) could translate to risks to patient safety and service quality was mentioned by a permanent staff at hospital A:

“There is a lack of control over them. We have safety nets and clinical audits and governance, and things get said back to us to improve the quality of care that’s delivered to our patients and to address educational needs for everybody, which is something they’re not part of, they’re not part of that service improvement process...Perhaps if they had been given a chance to get that feedback, they would get better” (Permanent 6, Hospital A).

The educational needs and clinical governance provided to permanent staff were not given to temporary staff, and if poor patient care is not rectified then temporary staff will continue to be a risk to patient care. Permanent staff at hospital B discussed ways in which feedback could be provided in an attempt to minimise these risks.

However, these were informal feedback methods and not the clinical audits and educational needs discussed by the permanent staff at hospital A. For example, permanent staff discussed the importance of providing feedback regularly throughout the day, and evaluating if temporary employees were coping with the tasks they were to complete. When doing this, permanent staff would then evaluate the temporary staff's capability, and suitable management of the temporary employee was then arranged.

In summary, staff banks at both hospital A and B offered temporary staff mandatory training free of charge, to be completed in their own time, with temporary staff aware that they would not be recruited if their mandatory training was not up to date. Clinical Managers relied upon the staff banks and agencies to undertake the necessary temporary staff checks. In an attempt to minimise risks to patient safety and service quality associated with training, the hospitals preferred to use temporary staff known to the department (as their skills and training would be known). Clinical Managers and permanent staff at hospital B also assessed the skills of staff when on the shift. The opportunity available for feedback and appraisals for temporary staff was limited as a result of the number of temporary staff used, and the fast paced environment of the ED. If a complaint or an incident was reported involving a temporary employee, the most common feedback in both hospitals was to not re-hire them. Concerns were raised about how corrective action and personal development were managed, especially with temporary agency staff 'managed' by the agency and not the hospital. Clinical staff at hospital B reported a culture of supervision and the provision of informal feedback in an attempt to minimise risks to patient safety and service quality. Implications for patient safety and service quality arise not solely in

connection to the specific EDs studied, but if training and development is not provided, then mistakes cannot be rectified for future placements.

5.7 Impact on Permanent Staff

Clinical Managers at both hospitals were quick to mention the increased supervisory demands on permanent staff that temporary staff required, including shadowing temporary staff (especially when unknown to the department), gauging their level of experience, and ensuring they were competent to undertake the roles required of them. In hospital B, with its culture of supervision in the ED, the presence of temporary staff meant: *“You cannot just let them come in and do the job, you have to get more involved” (CL, Hospital B)*. The amount of extra supervision required was dependent on the familiarity of the temporary employee to the department and the number of temporary staff hired on a particular shift. Operational efficiency, increased checks and providing on-the-job feedback became more onerous when more temporary staff were present. Not only did this affect the workload of permanent staff, but concerns were expressed about how the added stress affected the reduced morale of permanent staff.

Clinical Managers were conscious that increased supervision was dependent on the experience and skills displayed by temporary staff. In hospital B, the Matron discussed temporary staff having to be assessed by nurses to ensure they had the skills to undertake the roles delegated to them, with the Head of Nursing conceding that: *“If they have not got the necessary skills, then they will need more supervision, and then you are constantly looking over them” (HN, Hospital B)*. With the correct supervision, temporary staff were described as ‘an extra pair of hands’, and

managers were very specific with the tasks given to them and what was expected from them. Using regular temporary staff and the subsequent knowledge of their abilities, Clinical Managers were able to distribute workloads appropriately, using the temporary employee's strengths to reduce extra burdens on permanent staff.

At both hospitals the Clinical Managers acknowledged that in some circumstances the added burden placed on permanent staff was not the fault of temporary staff. For example, with medication administration there were limits to what temporary staff could do, as access to certain medications could only be gained through permanent staff. However, in some cases (especially with ad-hoc external staff), the added burden for permanent staff could become a greater hassle than help:

“We have a lot of things that are password limited, and ad-hoc locums may not have access to those electronic records...and every patient seen, has to be seen by someone who can justify and request, and it becomes much more of a hassle than help” (Clinical Director, Hospital A).

The Matron at hospital B considered medication administration as one of the major patient safety risks when using temporary staff. Consequently the restriction in place limiting access to medications by temporary nurses was considered to be a risk management intervention, with controlled drugs managed by the nurse in charge. Although this could increase the pressure on permanent staff, the Matron at hospital B argued that with careful delegation of activities to temporary staff they would be able to undertake duties such as observations, washing patients etc., and, *“In general, it is usually better to have someone than no one” (ED M, Hospital B)*. This showed how temporary staff could be effectively managed to reduce added burdens to permanent staff.

The Clinical Lead at hospital B discussed a practical burden when using temporary staff – the time taken to recruit them in specific situations. Although the hospital had a policy of hiring bank staff initially, when the internal staff bank was closed (out of hours, and at weekends), and the ED was understaffed, managers often resorted to ringing temporary agencies themselves, taking them away from providing patient care:

“We have a spreadsheet with people who’ve worked for us, people who’ve done locums before. We go through the list...which takes hours...the process of getting them in that situation takes hours” (CL, Hospital B).

Although there were preferred suppliers designated by the hospital, with pressures to reduce agency spend as cost-cutting measures, choice of temporary agencies was limited, adding to the time taken to hire suitable temporary staff, and the time taken away from providing patient care. The weekend closure of the staff bank often left the department with no other option than to use agency staff, increasing the burden placed on permanent staff and affecting service provision

All the managers understood that the demand for permanent staff time was increased when temporary staff were used, increasing the stress on permanent staff and influencing the speed at which they could provide patient care. Although patient safety was not considered to be at risk, service quality, and the timeliness of patient care was reported to suffer.

Permanent staff at both hospitals discussed having to take time away from patient care, the necessity of having greater awareness of the duties that the temporary staff performed, and ensuring temporary staff completed patient care to ED standards. This involved increased supervision and providing the medications temporary staff

needed to complete patient care, providing explanations about how the department works, showing them where relevant equipment was stored, checking that temporary staff had necessary skills and ensuring the paperwork for the patients they treated was completed correctly. This was in addition to their already busy roles, resulting in increased pressure in an already stressful situation:

“You have to take time off to explain things, and it doesn’t just stop at one explanation, because you have to be alongside them the whole shift. It takes time away that could be better utilised looking after your patients...it takes up my time and puts more pressure and stress on me added to the fact that I already have so much work on my hands” (Permanent 3, Hospital A).

Temporary staff also affected departmental throughput. When the time needed to supervise temporary staff increased, this affected the number of patients treated, increasing the pressure on the department. Although the 4 hour waiting time target was removed during data collection, participants still noted unofficial pressures for the timeliness of patient care, and saw the 4 hours as a bench mark for service quality. This increased pressure was described as a ‘domino effect’ by a permanent member of staff in hospital B, with: *“Everybody feeling that they’re struggling because they’ve got that person they’re having to support” (Permanent 3, Hospital B).* The increased workload (more patients to see, longer hours worked, ‘picking up the cracks’ of incomplete work) added to the emotional stress and pressure that individuals perceived, affecting staff morale.

Permanent staff reported being happy to work alongside regular temporary staff with relevant departmental knowledge, having confidence in their experience and ability to provide suitable patient care. Internal bank staff, who worked in the department,

were able to work independently and were trusted. Permanent staff expressed increased concerns about ad-hoc external temporary staff:

“Regular locums would just get on to the role they normally work...they’re like any other regular member of the ED. Locums who come now and again, who don’t come regularly to the department, they look for more help, more guidance” (Permanent 4, Hospital A).

Permanent staff described how the extra burden from temporary staff affected patient care in the ED, discussing the knock-on effect of increased workloads, working longer hours, reducing the time spent with each patient and the optimum degree of care given to them. On a practical level: *“You end up having to write a few lines less in your notes than you ought to, which again is a risk” (Permanent 6, Hospital A).* If there was a high proportion of temporary staff on a shift (particularly those unknown to the department), then attention to detail reduced if permanent staff undertook the workload of two roles. Delays in treatment decreased patient satisfaction, meaning that even if patient safety was maintained, service quality was affected. Other permanent staff understood the need to integrate temporary staff, hoping that if they helped temporary employees, then in return, the temporary staff would be happier to work in the department:

“If they feel that they’re respected as an employee, I think that even as a temporary member of staff, it’s much more likely that they will think positively about the experience, and therefore, I believe, that it will reflect in their work practices” (Permanent 1, Hospital A).

Managers need to be aware of the affects of temporary staff for permanent staff, and the implications for the ‘deal’ between permanent staff and management. Increased

workloads (resulting from increased supervision and undertaking tasks that temporary staff were unable to complete) led to greater pressure and stress for permanent staff who were often un-rewarded for the extra roles they undertook. If this was perceived as an unfair exchange, then it could affect performance, an indirect cost of using temporary staff:

“You have to look at the needs of your permanent staff and make sure that they feel that their needs are being met...you also have to ensure that the permanent staff who will essentially be supervising and looking after them are receptive to having them on board” (Permanent 1, Hospital A).

Permanent staff mentioned the differences in hourly pay between temporary agency and full-time contract staff. The hourly rate for agency staff is greater than permanent staff in the NHS, and permanent staff discussed a feeling of resentment, especially as the temporary role may be easier as temporary staff were unable to complete all patient care tasks. There was evidence of an unwillingness to help some temporary staff: *“If you don’t know somebody particularly well, you’re going to get on with your own work” (Permanent 5, Hospital A).*

Although Clinical Managers in hospital B reported a culture of supervision of temporary staff, one permanent staff member, having stated that they support temporary staff and would help when necessary, then reported *“I always make sure that my duties are done first, unless it is a dire emergency” (Permanent 2, Hospital B).* Although there was an expectation from managers that other team members will help temporary staff, this may not have always been the priority for permanent staff.

In summary, permanent staff and managers recognised that as a result of the increased supervision of temporary staff, and undertaking roles that temporary staff

may not be able to complete, permanent staff workloads increased, potentially to the detriment of service quality. Steps were taken to limit the effects on permanent staff. Hospital B had a culture of supervision, where permanent staff were encouraged to integrate temporary staff into the department, and the induction attempted to gain an understanding of previous roles undertaken by temporary staff so that skills could be allocated appropriately to minimise added burdens for permanent staff. Additionally, hospitals reported a preference for using internal bank staff, or staff who had worked regularly in the ED, as they were trusted to work safely and to ED standards.

There were barriers to the implementation of these steps. Staff at hospital B discussed the reliance on agency staff at weekends as a result of the staff bank being closed, limiting the opportunities to recruit preferred staff. However, no indication was provided about the frequency of using the least preferred agency staff. The knowledge that agency staff are paid a higher hourly rate in comparison to permanent staff, and the resentment this created provided a barrier to supervision. Limits on the access to medications for temporary staff also increased the workload for permanent staff, who then had to administer medication to patients treated by temporary staff (although this was originally introduced as a risk management initiative). These barriers had implications, most notably for service quality, as permanent staff took on additional duties, increasing their workload, delaying patient care, limiting their time spent with patients and influencing patient satisfaction.

5.8 Behaviours and Commitment of Temporary Staff

Participants often mentioned that the behaviours and commitment of temporary staff differed from permanent staff with potential effects on patient safety and service quality. As discussed in Chapter 2, the psychological contracts of temporary and permanent staff can vary in terms of their depth of relationship with management, and how this affects the behaviour and commitment displayed by staff. There was evidence suggesting how the employment relationships between managers and temporary staff could be best managed to minimise risks to patients.

Chapter 2 reported inconsistencies in research discussing outcomes relating to the performance, productivity and commitment of temporary staff (e.g. De Cuyper et al., 2008). The NHSP representatives at hospital A reported variable temporary staff experiences, with some temporary staff leading to more complaints regarding their attitude and competence (according to NHSP data mentioned in the interview, complaints were commonly associated with agency workers in comparison to multiple post-holders), however, with others, there would be no difference when comparing their productivity with permanent staff. The NHSP Site Manager noted the common ‘misconception’ about the performance of temporary staff (although, it is recognised that NHSP would speak positively about temporary staff, as their aim is to encourage and promote their use in hospitals):

“I think there is some misconception that flexible workers don’t do a lot when they’re on shift. Yes, there are flexible workers who don’t do a lot, and equally there’s a lot of permanent staff who don’t. Then on the other side there’s some very good workers who choose to work flexibly” (NHSP SM, Hospital A).

The behaviours and commitment displayed by temporary staff could be linked to volition – with the NHSP representatives reporting that for many temporary employees working extra shifts meant their professional registration was maintained whilst they were studying, or temporary shifts allowed them to manage their work schedules, choosing when and where they worked. Complaints regarding the commitment of temporary staff were reported as being minimal (the NHSP Site Manager was unable to provide an example at hospital A when registration had to be terminated) – but attendance (the failure of a temporary employee to work a shift) was reported as an issue for which NHSP had a policy – continued non-attendance would result in being removed from the bank register. Non-attendance led to increased pressure on the ED, which was already understaffed, affecting the service quality that patients received.

At hospital B, the Bank Manager stated that in their opinion, most temporary workers chose temporary contracts as a result of the flexibility it provided and because of the added income (especially if recruited through temporary agencies). It was assumed that when working as a temporary employee, there was a limited necessity to take on the full responsibilities of the role, and temporary staff could just *“Come and go as they like without having to take on the full weight of the worrying and planning forever and ever” (IBTSM, Hospital B)*. It was inferred that temporary staff did not have the same level of performance and commitment in comparison to permanent staff.

The staff bank representatives at both hospitals suggested that to gain maximum performance and commitment from temporary staff it was best to use multi-post holders to cover vacant shifts. Staff would have developed a relationship with those they work alongside, feel committed to the department, and would work to ensure

patient care was delivered appropriately, minimising the affects for permanent staff. Clinical Managers at hospital B asked permanent staff who undertook occasional temporary shifts to work through the staff bank, highlighting that the staff bank had priority over agencies. The staff bank recognised that temporary agencies paid more than the bank, and the financial incentive was a major pull towards agency work. But with the drive to reduce agency staff for both cost saving and patient safety and service quality reasons, if individuals wanted to supplement their income they would have an increased opportunity to do this through the staff bank. How successful the recruitment drive to the staff bank had been was unreported.

The role of Clinical Managers and permanent staff in promoting positive behaviours and commitment was also discussed, although this was dependent on a number of factors, including the proportion of permanent to temporary staff during a shift, and the level of supervision permanent staff were able to provide. Risks to patient safety and service quality were perceived to increase in proportion to the number of temporary staff used, as the level of permanent staff to supervise, encourage and support temporary staff was reduced.

Clinical Managers at hospital B believed that sweeping statements regarding the behaviour and commitment of temporary staff could not be made: *"I am not saying that they're all bad, because they're not; there are some very, very good ones. But when they're bad, they can be very bad"* (ED M, Hospital B). When asked for examples of the range of behaviours displayed by temporary staff, the Matron stated that some took long breaks, were found sleeping on shifts, and others were slack whilst undertaking basic patient observation skills. The reliability of temporary staff was reported as an issue, either cancelling shifts at the last moment, or failing to attend. However, the Matron added that miscommunication with the staff bank or

agencies and the ED added to problems, and temporary staff were not always at fault. Conversely, the Matron also provided examples of temporary agency staff who had been helpful on shifts, conscientious and committed, to the extent that temporary staff had been recommended to apply for permanent positions.

Explanations relating to why temporary staff displayed high levels of commitment and performance were provided by Clinical Managers at hospital B. The Clinical Lead suggested that when individuals undertake temporary shifts, they have no other commitment to the organization other than to deliver safe patient care, consequently they can spend their time focussing on this. Additionally, temporary staff have different expectations to permanent staff regarding what the department will offer them, and so they behave accordingly: *“They’re not expecting to be trained, they’re not expected to be educated. They are just coming in, doing the job and going home again” (CL, Hospital B)*. Recognising that many temporary staff undertake extra shifts to supplement their income, the Head of Nursing suggested that commitment between temporary and permanent staff does not differ as: *“Temporary staff know that this is their bread and butter as much as permanent employees do, and they know that if they don’t do a good job they won’t be back” (HN, Hospital B)*. This suggests the development of a relationship between temporary staff and the department, with the expectation that if they perform well, they will be re-hired.

At hospital A, the Administrative Service Manager stated that new temporary staff were not as committed to going the extra mile to collect all the necessary patient information, however this was related to the limited understanding of their role. Those employed regularly were perceived to show greater commitment and, *“As time goes on they have a better understanding of the role and the importance of the role” (ASM, Hospital A)*. They noted that commitment was reduced as temporary

staff did not have a relationship with the department – if temporary staff did not like the role, they had the flexibility not to return. The development of employment relationships based on contract type was highlighted by the Clinical Director at hospital A: *“(When temporary staff become permanent) they become even more motivated, so if they chose to abandon the agency trap for a substantive role...you see a step up in their level of motivation generally” (CD, Hospital A)*. When temporary staff became permanent employees, they were offered development opportunities, guidance to pass medical exams and training, and in return, the commitment from the employees increased accordingly. The Clinical Director stated they would encourage ‘good’ temporary workers to become permanent if a vacancy arose, so they could nurture staff.

Permanent staff recognised the relationship between the regularity of the temporary employee in the ED and their level of commitment. Staff felt that it was ‘natural’ for there to be limited vested interest in what was occurring in the department if the temporary employee was not going to return:

“I think there is probably a mentality of, well I am not going to be here tomorrow, so I’ll just do what I can while I’m here and then I’ll get out the door as quickly as I can, and when I leave it’s no longer my problem” (Permanent 1, Hospital A).

This was considered especially prevalent in London, where there are greater opportunities for working in a number of hospitals in comparison to rural areas. Those on longer-term contracts and employed permanently were perceived to have a closer relationship with the department than temporary staff, consequently displaying greater levels of commitment. As a result of this employment relationship,

employees felt obliged to display a 'team-player attitude', working towards departmental goals. Other permanent employees argued that recruiting temporary staff did not always equate to extra workers, as they did not always deliver patient care to the same number of patients per shift. This affected service quality and increased the permanent staff's workload:

"It's that lack of responsibility and the feeling of ownership to the department or the hospital, and that translates into a little bit of slackness...so that then increases the working load pressure on the person who has to pick up the pieces" (Permanent 6, Hospital A).

When temporary staff worked regularly in the department, having the opportunity to develop employment relationships with those they worked alongside, permanent staff reported a greater vested interest in both attitudes towards patient care, and the roles they undertook and were described as being aware of departmental pressures. This variability in temporary staff performance was assumed, by some permanent staff, to be linked to their motivation for undertaking temporary roles. For example, temporary agency staff were paid more for their shifts than permanent employees, and when the main incentive for temporary work was economic, performance and commitment was perceived as limited in comparison to permanent staff. However, commitment and behaviour for those using temporary employment to gain a permanent position was perceived as equal to permanent staff, as this increased their opportunity of returning to the department:

"With regards to attitude and commitment, because they are temps, it might sound really weird, but they have to be on their best behaviour and present themselves well to both the employees and employers and the patients,

because they want to return to the place and they need to give a good perception of themselves” (Permanent 2, Hospital B).

Permanent staff provided ways in which the management of temporary staff could be improved to minimise the effects of reduced commitment among some temporary staff. The importance of recruiting temporary staff known to the department was often cited. However, as this was not always possible, participants at hospital B stated that temporary staff should have the minimum standard of care expected from them clearly defined as they enter the department, to minimise differences in perceived expectations from both sides: *“They need to know what we expect from them and the minimum standard of care they feel they should provide” (Permanent 1, Hospital B).* Permanent staff at hospital B also noted the importance of communication, reminding temporary staff of departmental targets and encouraging commitment. Staff at hospital A felt that attitudes and behaviours were perceived as reduced among temporary workers as they were not as communicative with those who worked alongside them. Encouraging communication leading to positive behaviours was seen as important for reducing risks to patient care. Developing this, another staff member at hospital A stated: *“If temps are enjoying their time there, if they feel they are respected even as a temp, they will think more positively and this will be reflected in their work practices” (Permanent 1, Hospital A).* If temporary staff were integrated into teams, supervised and included in communications, it was believed that their behaviours would become more vested towards their role, improving patient care.

In summary, participants had differing perceptions of the behaviour and commitment of temporary staff, recognising variability and suggesting that the common conception that temporary staff reduces performance should not be applied to all

temporary employees. The individual's motivation for undertaking temporary employment was perceived as a factor explaining behaviour, for example, permanent staff commented that temporary staff seeking full-time employment performed as well as permanent staff. The behaviour and commitment of temporary staff was also associated with their familiarity with the department. Participants reported difficulties in ensuring positive attitudes and commitment among temporary staff, including the inability to recruit familiar temporary staff, and barriers in communication with some temporary staff. In an attempt to minimise these risks, using regular temporary staff and developing a culture where communication between temporary and permanent staff is encouraged, were suggested as methods to lead to positive performance and patient outcomes.

5.9 Brief Summary of Results

This study aimed to look at the management of temporary staff in two EDs and the implications of their use for patient safety and service quality. A number of reasons why temporary staff were used at hospitals A and B were provided. The Executive Directors discussed the need for flexibility in staff vacancies to control for fixed term costs while also recognising that temporary staff were required to cover for sickness, training, short-term staff absences, maternity leave and vacancies due to recruitment difficulties. Executives at hospital B also mentioned patient safety with temporary staff recruited to ensure adequate staffing levels. This led to a cost vs. patient safety dilemma, as it was recognised that some temporary staff (especially agency staff) were more expensive than permanent staff. Clinical Managers and permanent staff described temporary staff use as 'need driven' – with EDs requiring a sufficient

complement of staff to operate. Clinical Managers at hospital B highlighted maintaining performance levels and the need to adjust staff rotas as a result of poor staff satisfaction survey outcomes, necessitating the hiring of temporary staff.

Policies, procedures and practices for hiring temporary staff were discussed, with the underlying preference for temporary staff familiar to the department. Although procured differently (hospital A using NHSP and hospital B using an internal staff bank), both hospitals highlighted prioritising staff banks for two reasons: the majority of staff in the banks were already employed in the hospitals and considered safer for patient care, and staff banks were cheaper in comparison to agency staff. When staff banks could not provide necessary cover, agencies were used, although they had to be part of the hospital's framework agreements, to maintain maximum safety standards. Clinical Managers and permanent staff at both hospitals expressed a distinct preference for using regular temporary staff, however, they conceded that ad-hoc staff were preferable (generally) in comparison to the position remaining unfilled.

Neither hospital could provide data linking temporary staff to increased risks to patient safety and service quality. However there was the general perception that some temporary staff did pose a risk to patient safety and more particularly to service quality. Permanent staff perceived the level of risk to be proportional to the number of temporary employees during a shift, and the variability among temporary staff made risks difficult to quantify. Participants also noted that if an incident involving a temporary employee occurred, other factors contributing to the incident must be considered – including the number of staff on shift, the level of support the temporary employee received and whether an induction had been given – highlighting the importance of the system in which the temporary employee is based.

Ways in which temporary staff could affect patient safety and service quality were identified. Limited familiarity with the geography of the department (leading to delays in medication administration and longer time spent undertaking basic tasks) was commonly cited, most notably when ad-hoc temporary staff were employed. Familiarity with the team was discussed, with maintaining team cohesiveness provided as a method through which errors could be reduced, as communication and information transfer happened more readily. Participants discussed barriers to staff integration, including permanent staff acknowledging that temporary agency staff earn more per hour than permanent staff, and on occasions undertake fewer responsibilities, leading to a reluctance to aid or supervise temporary staff.

Temporary staff were not given feedback and appraisal opportunities afforded to permanent staff, which meant that learning from mistakes became harder for them. Both hospital banks provided mandatory training to temporary staff free of charge (bank-only), however, it had to be completed in their own time. Temporary staff would not be recruited unless their training was up to date. The behaviour and commitment of temporary staff were described as dependent on the individual, related to their motivation for undertaking temporary employment and their level of familiarity with the ED. Permanent staff reported having to undertake extra supervisory roles, and complete tasks not undertaken by temporary staff, increasing their workload and affecting their opportunity to treat patients they had been assigned, once again indicating negative implications for service quality.

Ways in which these risks could be best managed were discussed, focussing primarily on hiring temporary staff known to the department and increasing the opportunity to maintain or develop an employment relationship with them. Managers at hospital B prioritised the staff bank, and encouraged those wishing to

undertake temporary work to register with the staff bank, with the knowledge that it was the first point of call when arranging temporary cover. This initiative was to increase the proportion of temporary staff known to the hospital, whilst reducing costs associated with temporary staff. At hospital A, although NHSP arranged temporary staff, they did not have a contract for locums, and consequently agency staff had to be recruited.

Staff in both hospitals discussed the importance of staff induction (especially with ad-hoc staff), and temporary staff also attended the handover (hospital B). Clinical managers at hospital B added inductions should include clear departmental expectations of the role the temporary employee should be undertaking, and verify what roles they had previously undertaken to gauge their level of skill. Staff at hospital B reported a culture of supervision, where support, communication and informal feedback between staff was encouraged to develop employee relationships, believing this would minimise risks to patient safety and service quality when using temporary staff.

Broader issues regarding the management of temporary staff became clear. Participants at both hospitals reported staff vacancies in their EDs with difficulties in recruiting permanent staff to positions. Problems with recruitment to EDs are not restricted to the hospitals studied, with national shortages in ED staff as a result of changes in training, the introduction of the European Working Time Directive and bad publicity arising from inquiries into poor patient care (Dyer, 2011). Agency staff were more expensive to hire than bank staff (and more expensive per hour than permanent staff), and consequently the hospitals were introducing policies to incentivise staff who wanted to work extra shifts to register with the staff bank, so the hospital could recruit them. However, managers had little control over the

potential for their employees to sign up with agencies, where they have the opportunity to earn more than working for the staff bank. Pay incentives and developing an employment relationship to encourage commitment to the hospital's staff bank are necessary to aid patient safety and service quality improvements and reduce spend on temporary staff. Additionally, if hospitals wanted to reduce agency costs and provide optimum levels of patient safety and service quality, the inability to recruit staff through staff banks (especially at hospital B) at weekends seemed to contradict both aims – as hospitals resorted to agency staff, more likely to be ad-hoc and lead to risks.

The popular negative perceptions of temporary staff, the mixed experiences of those who hire and work alongside them, and the absence of any systematic data monitoring both the use of temporary staff and their involvement in patient incidents were evident through data analysis. Current policies and practices in the management of temporary staff and their employment relationships are seemingly largely determined by the day to day experiences, impressions and in some cases potentially biased judgements of those interviewed. The next chapter discusses the results of the second study focussing on the management of a specific form of temporary employment – the Consultant Resident On-Call. Results from both studies will be discussed with reference to the literature, including in particular the psychological contract, to develop a model of best practice for the management of temporary staff.

Chapter 6: Findings of Study 2: The Launch of Major Trauma Centres in London

6.1 Introduction

This chapter presents the findings of the Major Trauma Centre (MTC) study that focussed on a distinctive form of temporary employment – the Consultant Resident On-Call (CROC) for trauma, a twenty-four hour consultant led service in a South London Hospital’s newly established MTC. When the MTC was launched in April 2010, the consultants worked as the CROC on a locum basis whilst their contracts were negotiated. During this locum period, consultants who worked as the CROC signed up to shifts voluntarily (in addition to their normal work) and when employed as the CROC, were paid a locum rate. In essence, the consultants were temporarily temporary – providing a novel dimension to the study of temporary staff in healthcare.

MTCs were developed following the report “Healthcare for London: A Framework for Action” (Darzi, 2007), which identified shortcomings in trauma care delivery and presented evidence-based proposals for methods to improve the quality of trauma patient care. The MTC designation criteria required a twenty-four hour a day, seven days a week consultant cover for major trauma (Healthcare for London, 2009) as evidence suggests that early senior decision making is beneficial for patient management by enabling swift, efficient and effective interventions with fewer patient referrals (Anderson et al., 1988; Cooke, et al., 1998; Albert and Phillips, 2003). When trauma patients are seen in the ‘golden hour’ after the trauma occurred, survival chances improve. The CROC leads a trauma team (comprised of an

anaesthetist, a trauma surgeon, an orthopaedic surgeon, an ED registrar and ED nurses), the CROC being a ‘hands-off’ role, orchestrating the care provided.

6.2 Aims of this Study

This study aimed to explore the management and employment of this distinctive form of temporary staffing. By focussing on consultants already employed at the hospital but recruited as locum consultants to undertake the CROC for major trauma, the study extends the literature on temporary employment in healthcare which has tended to focus upon nursing staff working temporarily for ad-hoc shifts.

The study aimed to understand why management staffed the MTC with locum consultants, why the particular consultants were chosen, and whether employing consultants as locums altered their employment relationship with the organization. The MTC was introduced to improve trauma patient safety and service quality; however this might be achieved at the expense of the consultant’s quality of working life through the changes in working hours. The study aimed to determine if contract changes affected quality of working life and whether this in turn affected patient safety and service quality. The results are discussed with reference to the employment relationship, and whether the CROC affected the ‘deal’ consultants had with hospital A, and the implications for patient safety and service quality.

In addition, the study briefly compared how hospital A launched the MTC with two other London hospitals also designated as MTC’s, assessing how the management of the launch differed between the hospitals, and whether hospital A could have managed the process differently to improve the ‘deal’ with the consultants and patient safety and service quality.

6.3 Sample Characteristics

Semi-structured interviews were conducted pre and post MTC launch. The interviews focused on the launch of the MTC and CROC, the experience of working on a locum contract, the specific experiences of the CROC rota, the negotiations of new consultant contracts, how this process was managed and the implications for patient safety and service quality. For both interview cohorts, all the consultants from ED and ICU were invited to take part in the study (23 consultants in total). Participation was voluntary.

For the pre-launch interviews, 13 consultants volunteered to be interviewed. Of these, 6 were from ED (4 male, 2 female), and 7 were from ICU (4 male, 3 female). Participants had been in their current consultant role for varying lengths of time (ranging from one who had not started their position yet, as they had been hired especially for the MTC, to a consultant who had been in post for 6 years. One consultant was hired solely on a locum basis).

In the post-MTC launch interviews (starting 8 months after the MTC launch) 10 consultants were interviewed. Of these, 4 came from ED (3 male, 1 female, all interviewed pre-launch), 5 came from ICU (all male, 3 of which had participated pre-launch, 2 came forward post-launch). This wave also included 1 consultant Anaesthetist (female) who was asked to participate as a CROC due to their extensive trauma experience.

Post-launch interviews also included two Clinical Directors (one from ED and one from ICU) involved in the management of the MTC or the development of new job plans for the consultants involved. Management representatives from two other

London MTC's were also interviewed some time after their MTC's had been launched.

6.4 Consultant Perceptions of Reasons for Introducing Major Trauma Centres (MTCs)

The consultants cited a number of reasons for the introduction of MTCs. Many recognised the contribution of Lord Darzi's report about healthcare in London, believing this provided the necessary political imperative, as it had been recognised for some time that trauma care in London was substandard:

"It has always been identified that trauma care is at a substandard level nationally, but it has only been with the introduction of Darzi's vision...and the recent reports by the National Audit Office where they've really acknowledged care is substandard...we've been given the backing to do it now" (EDC 2).

Many consultants described how the hospital already acted as a trauma centre in some way, as hospital A received a majority of serious incidents in the area. The consultants acknowledged that the political and governmental imperative resulted in funding becoming available for the development of MTCs, providing necessary resources for it to run efficiently: *"There's a potential for quite a lot of funding which is what got everyone's hopes up...it's significantly growing the services, without costing an awful lot" (ICUC 3).*

Another factor cited by consultants was that hospital A would gain increased kudos and recognition in the trauma field, hoping this would lead to securing further hospital services:

“It brings with it a large degree of kudos, the opportunity to be something different from the norm, and because of the wide range of skills required to maintain a trauma centre, to a certain extent it ensures a legacy for the hospital” (ICUC 5).

These views were supported by a Clinical Director for ICU (CD ICU), involved in job planning and designing the new contracts. As well as already having the specialist services necessary to provide major trauma care (apart from plastics), kudos over other hospitals in the area was a significant factor for its launch: *“(The hospital) wanted it strategically because it made us better than (hospital x)...therefore there was a real push to make the Trauma Centre happen” (CD ICU).* The introduction of the MTC also provided the opportunity for research grants and increased research outcomes as a result of having increased major trauma cases.

The Clinical Director for Emergency Medicine (CD ED) stated the case for MTC's in London had been recognised for a number of years, based largely on increasing international evidence supporting the efficacy of MTCs for patient outcomes. As previous attempts to improve trauma care had been made, initial decisions to go forward for designation to become a MTC should funding become available had already been made; and having a large ED and a regional neuroscience centre meant that hospital A was a suitable MTC site.

In summary, participants recognised the role of the Healthcare for London report and the need to improve trauma care in London. They also noted that the hospital had

the necessary facilities on-site for treating trauma patients, and acknowledged the kudos that being an MTC would bring to the hospital.

6.5 Perceived Reasons for the Distinctive Approach to Staffing and Organising the MTC at Hospital A

Healthcare for London's (2009) proposed business case for developing a model of trauma care with direct access to dedicated specialists and trauma treatment specified that: *"The new Major Trauma Centres will treat patients with the most serious injuries 24 hours a day, seven days a week, providing the highest quality care through a consultant led service"* (page 27). Hospital A met this mandated requirement in three distinct ways. First, it was decided that while the MTC was being set up it would place consultants on temporary locum contracts when they were working as CROCs. Secondly, it would require consultants to be resident on-call for 24 hour shifts. Thirdly, rather than recruiting from outside, it would use consultants from two specialties – the Emergency Department (ED) and the Intensive Care Unit (ICU). These arrangements led to changes in working patterns.

In pre-launch interviews, the consultants offered a number of explanations for why the hospital staffed the MTC in this way. Most suggested that the ED did not have sufficient consultants to make a 24 hour rota sustainable and financial constraints limited the recruitment of further ED consultants, necessary for a workable rota: *"I think there is a hospital issue...they have not got enough money to recruit A&E Consultants to be the Trauma lead"* (EDC 5). With the addition of the ICU consultants, the major trauma rota became sustainable.

Some consultants viewed the joint specialty staffing as a political move, stating that ICU were involved to develop their services and facilities as a result of the funding the MTC provided: *“I think Critical Care has got involved because we desperately want a new, bright shiny co-located unit, and people have used the Major Trauma Centre as an opportunity to push that agenda forward” (ICUC 1)*. It was mentioned that ICU consultants had relevant skills that could cross-over to trauma care, further justifying their choice. However, the implications for patient outcomes were uncertain:

“It’s quite an interesting model of working, because I am not aware of anywhere that’s got this joined-up relationship of two specialties working together for the same group of patients...(it will be) interesting to see how it goes...and the (impact on) outcomes of the patients to see how the two different groups work” (EDC 1).

The two specialties originally decided to cover the mandated consultant presence differently – ED consultants providing cover in 12 hour shifts, and ICU consultants were on-call for the full 24 hours. The decision to cover trauma in this way was considered to reflect personal preferences. Towards the end of data collection when the new contracts were almost finalised, it transpired that both ED and ICU consultants had opted for 24 hour shifts. Perhaps paradoxically, this decision was taken to improve the quality of working life when undertaking the CROC:

“The pressure on the ED on-call commitment is really quite intense...couple that with this (CROC), they felt that intensity meant that if you divided 24/7 into two 12 hours, the frequency that you’re doing some form of on-call was huge” (CD ED).

From a managerial perspective, using two specialties to staff the MTC was a strategic choice to ensure hospital A had enough staff on board to ensure a successful bid. However, at this level there was disagreement regarding how committed the relevant specialties were to the scheme, leading to slightly different perspectives about why the unique model arose:

“...There was a real push to make the trauma centre happen and one of the ways of doing that was a group of Critical Care consultants said we would staff it. ED were quite reluctant.” (CD ICU)

From the ED perspective, one of the initial leaders in the MTC development was originally from Critical Care, consequently gaining support from the ICU consultants. This individual left the hospital before its launch, leaving the practicalities and consequences of the launch to others. The Clinical Director for Emergency Medicine (who took over lead responsibility, but was not involved in the setting up and planning of the MTC) emphasised that ED consultants were also committed to the MTC, *“What was very clear is that the ED and Emergency Medicine were completely committed and very enthusiastic” (CD ED).*

Another reason cited for the unique staffing model was the perceived importance of multi-disciplinary working, using integrated teams to improve other patient pathways based on the management of trauma. The dual-specialty model was intended to develop a broader hospital wide commitment, engagement and collaboration between the two departments. However, the ED Clinical Director questioned the sustainability for this dual-specialty model, indicating that ICU consultants may be less committed to the MTC, as trauma was not their major specialty and suggested the CROC duplicated roles undertaken by ED consultants,

questioning the cost-effectiveness of the approach, and whether there could be cheaper methods of providing the service.

Representatives from two other London MTCs were interviewed about the development of their MTCs in comparison to hospital A. Hospital C's MTC was described as a, "*Busy, dynamic, organically evolved trauma centre*" (Hospital C), and the mandated 24/7 role was staffed by ED consultants already employed at the hospital, who became the trauma team leaders working 24-hours in-house. The consultants did not work solely as trauma consultants – but trauma was in their job description, with time allocated to the trauma service and on-call commitments (with a slightly higher on-call pay). This MTC was in place before Darzi's report, and the hospital was keen to share their trauma model:

"We were keen to make sure they (other London MTCs) could leap through all the years of development that it had taken us, and at least there was a model system which wouldn't be applicable in its entirety...but at least there was a model." (Hospital C)

Hospital D's MTC also covered the 24/7 trauma consultant presence solely with ED consultants. The hospital, at the time of interview, had 18 consultants in post for trauma, soon to increase to 21 (to allow for a workable rota), highlighting their investment in medical staff. However, at hospital D, the consultants had not always been based in-house. The hospital originally had five ED based trauma consultants, and made the pragmatic decision (due to financial planning and investing in consultants with a distinct interest in trauma) to increase CROCs over a period of two and a half years. To ensure the hospital had adequate staff for the MTC launch, staff were recruited from a number of sources, including hospitals in the trauma

network (a trauma network is the collaboration between the providers commissioned to deliver trauma care in a geographical area – with a MTC at the heart of the network (NHS Clinical Advisory Groups, 2010)). The representative at hospital D explained the recruitment process:

“ED consultants from our trauma network...or we used some internal people...it was by expression of interest – ‘are you happy to come and lead the trauma team?’ And that was primarily for out of hours work because we had ED Consultants there anyway.” (Hospital D)

The management at hospital D used this recruitment method to staff the rota with those willing to undertake the trauma role in the way it was mandated, and stopped using external staff when enough ED consultants had been permanently recruited.

In summary, hospital A management chose a distinctive model, markedly different from hospitals C and D. The reasons for this are difficult to confirm because the main manager involved in the decisions had since moved on. However, it appeared that there were some negative factors, including the desire to minimise costs by using internal staff and the slow progress in agreeing a new contract, and positive factors associated with the perceived benefits of greater integration.

6.6 Consultant Contracts for Trauma

Pre-launch interviews indicated that although the joint specialty arrangement was introduced partly to provide sufficient numbers for a workable rota, little information had been divulged by management about how vacancies resulting from sickness and annual leave would be filled. Contingency plans were limited if further vacancies

arose. Furthermore, new job descriptions had not been prepared and no revised contract had been drawn up or agreed. Therefore, until a sustainable rota and job plans had been agreed, management decided that the consultants would work as locums (and paid locum consultant rates when working overnight), when signed up voluntarily for specific shifts.

From a managerial perspective the locum contract was initiated as hospital A needed immediate sign-up so the MTC could be launched, and because consultants were already working additional hours of programmed activity such as teaching or research. Additionally, the proposed working hours were atypical and compensation for these changes had not been negotiated:

“...They wanted immediate sign up...you can’t just tell someone to be resident on-call when it is not standard for consultants and no one therefore knew how much you should be paid or how you could negotiate that payment...(so the way) to make it happen quickly was to pay people extra money for doing it.” (CD ICU)

Locum contracts were also introduced because there was uncertainty at hospital A about how to interpret the requirement for the resident on-call (a key element of the designation criteria). The ED Clinical Director stated there was, *“A denial that this (24/7 working) is what the detail meant...24/7 resident consultants is a big step, not particularly tried and tested” (CD ED)*. Management were unprepared for the MTC launch, and felt they had to pay consultants the locum rate to undertake the rota and remunerate them for the changes to their working hours: *“We managed to agree, by the skin of our teeth, before go live date, this sort of hybrid temporary arrangement of locum payments for the consultants contributing to the rota.” (CD ED)*

Some consultants thought the locum arrangement was positive, in that the experience would provide a preview of what the role involved, whether they liked the work and change in work pattern, and whether they wanted to become a CROC permanently after the locum period:

“It may allow people to look at it, at relatively attractive rates and go, ‘okay, I think I could do this’ or ‘absolutely not on your Nellie, there’s no way I can do this’ and I think that is important” (ICUC 3).

The locum period also meant consultants could choose what shifts they wanted to cover, and because of the locum rates, meant they would be well paid for their time: *“You’re working more frequently than you would ever sign up to do in the longer term, but you’re being well remunerated for it” (EDC 6).* Consultants were clear that shifts should be covered by internal locums, preferably those who would be working as the CROC officially, as a result of risks identified when using external locums with regards to their lack of familiarity with the different hospital environment. If external or unknown consultant locums were employed to lead trauma, this could affect team management balance as an unfamiliar individual would be expected to co-ordinate the team and there would be limited knowledge about how prepared they were for the role.

In summary, consultants were originally asked to undertake the CROC on a locum basis as a pragmatic solution to cover the MTC rota, since negotiations for new contracts had not been completed. In exchange for this uncertainty and to ensure the role was covered, hospital A agreed to pay locum rates when covering shifts overnight. Consultants viewed this as an opportunity to find out whether they would

be suitable for and like the role, and saw the financial remuneration as justified in relation to the work they were undertaking.

6.7 The Impact of the CROC Arrangements on Patient Safety and Service Quality: Pre-Launch Interview Findings

The following section describes the results of the analysis of the 13 consultant pre-launch interviews, with reference to how the launch of the MTC, the changes to consultant contracts, the management of the process and the impact on staff could affect patient safety and service quality. This and the later section describing the post-launch interview data, are organised in this way because the primary aim of the MTC was to improve trauma care. The key focus is on how the management of the process, including the temporary locum contracts, the staffing of consultants from two departments and the process of negotiating longer term arrangements affected patient outcomes.

6.7.1 Pre-Launch Analysis of Potentially Positive Effects on Patient Safety and Service Quality

The following section presents the analysis of the pre-launch interviews, with consultants describing how the implementation and management of the MTC and the CROC could lead to positive patient outcomes, including any implications for the ‘deal’ between management and the consultants.

Figure 1 displays pathways for the perceived improvement to patient safety and service quality of trauma patients (either directly or indirectly) as a result of the

launch of the CROC as discussed in the pre-launch interviews. Within this, examples of how this change in employment relationship to a distinctive form of temporary contract altered the consultants exchange relationship with the organization, and the affects for patient safety and service quality are discussed. The results are discussed with reference to the management of the process, and whether decisions made by management helped or hindered the aims of the MTC.

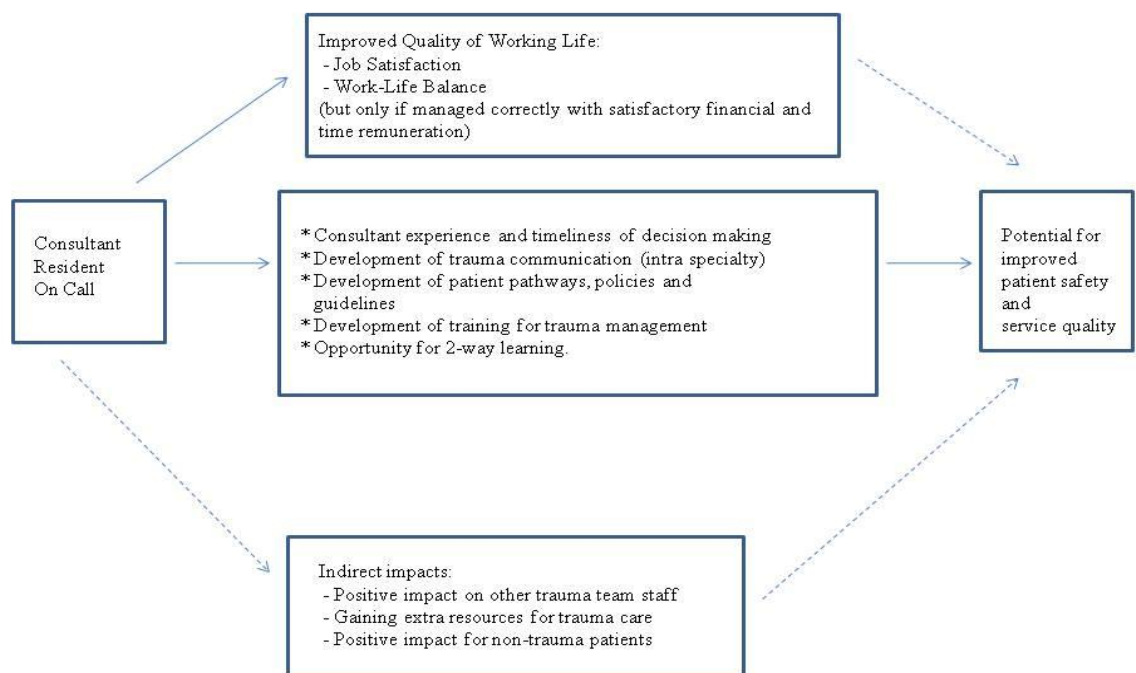


Figure 6.1: Pathways indicating how patient safety and service quality may potentially be improved as a result of the CROC.

6.7.1.1 Direct Pathways for Improving Patient Safety and Service Quality

Consultant Experience

The main aim of the MTC was to improve patient safety for major trauma patients. ED and ICU consultants expected that having the CROC would mean that trauma patients would receive immediate treatment from experienced clinicians. ED consultants felt they already had the necessary experience and expertise:

“Consultants, they’re exposed to it (trauma) and work with it on a daily basis...you develop a situational awareness of it. You’re perceptive to what’s going on and that only comes with experience....you tend to know what investigations are going to need to be done” (EDC 1).

ICU consultants believed that they would have the necessary experience even though they were not usually involved in patient trauma care from the outset of the patient’s arrival: *“If I was critically ill coming into an A&E...I wouldn’t want a junior doctor looking after me, I’d want the consultant who had been doing it for many years...critically ill patients need experienced doctors” (ICUC 4).* This reflected a view among ICU consultants that having the consultant’s experience would be beneficial for patient care regardless of their specialty.

Development of Trauma Communication

Consultants thought having joint specialties covering the CROC would lead to the development and improvement of intra-specialty trauma communication and improved consultant-to-consultant communication, the latter especially linked to improved patient pathways and timeliness of patient management. The MTC aimed to improve the timeliness of patient care and improvements in consultant communication would aid this:

“At the moment if there’s something wrong with the patient the junior doctor will refer to their registrar in their specialty, who will then refer to their consultant in their specialty. That consultant will then tell one of their juniors to phone an equivalent junior on the other side and then it will go up the other specialties hierarchy. Hopefully all of that will be categorised right from the outset. You will just have one consultant speaking directly to another consultant” (ICUC 4).

The development of trauma team meetings discussing trauma patient care was described as an important addition to patient management leading to improved patient care, as consultants would be able to evaluate how patient care was delivered, where improvements could be made and discuss continuing care plans. Consultants believed that patient safety would improve as the MTC could lead to the development of clearer patient pathways and trauma protocols, ensuring the patient receives the necessary treatment in the ‘golden hour’ following the trauma incident: *“It is building up better relationships with your specialties and making a better structure on how referrals are made and how the co-ordination of care occurs” (EDC 2).*

Development of Training and Learning Opportunities

The proposed launch of the MTC created learning and training opportunities to ensure all the consultants had the relevant skills to conduct procedures that the CROC needed. Although training for trauma care had been offered, it had not been made compulsory for all those undertaking the CROC, with some consultants reporting that not all consultants had yet been on the training. Although not attending training could affect patient safety, other structures were in place, for example, the major trauma team (having core skills) would ensure successful patient

treatment. Other forms of training were being developed, including a ‘Trauma Leader’ course – looking at the psychology of team leadership, including simulation situations, so there was conformity and structure in how CROCs should manage trauma cases. ICU consultants mentioned that the joint specialty model encouraged two-way learning, as both specialties could offer skills for trauma management: *“It can be a really good two-way learning process. I’m sure we’ll learn lots from being in A&E and working with them” (ICU 3)* and *“...If they are receptive to having us there, then I’m sure there is lots that an intensivist in an A&E department could offer” (ICUC 7)*.

In summary, consultants understood that having the CROC was necessary, not only because it was mandated by Healthcare for London, but because the experience and knowledge of consultants would improve the timeliness of trauma care. Having a CROC could directly improve patient safety as communication structures, training and learning opportunities would evolve as a result of the joint-specialty rota.

6.7.1.2 Indirect Pathways for Improving Patient Safety and Service Quality

Nicol and Botterill (2004) argued that the ‘more flexible’ working pattern associated with on-call employment in healthcare is necessary for service provision but may not necessarily lead to a greater quality of working life for employees. The CROC required being resident in the hospital for 24 hours, potentially going against the spirit of the European Working Time Directive (EWTD) (an initiative introduced to improve the employee’s quality of working life by limiting the working week to 48 hours, regulating the number of hours worked per day, and legislating the number of hours of continuous rest required after a working day, and in healthcare improving

patient safety by reducing the risk of patients being treated by tired staff). To be resident on-call for 24 hours necessitated time off before and after the CROC shift as a result of the EWTD.

Implications for the consultant's quality of working life, the employment relationship, and patient safety were identified in pre-launch interviews. For the purpose of this analysis, quality of working life is split into work-life balance and job satisfaction.

Work-Life Balance

Undertaking the CROC was perceived by ED and ICU consultants to potentially improve work-life balance if launched properly – allowing for proper compensation in terms of time off: *“It means you have a significant amount of time that’s mandated as rest before and afterwards...it’s up to you to do with that time what you wish...”* (ICUC 3). The impact on work-life balance was perceived to be dependent on the frequency of CROC shifts which, pre-launch, was unknown.

Some consultants were cautious about the true impact on work-life balance as the frequency of CROC shifts would be dependent on the number of consultants participating in the rota: *“If we manage to find enough people to do it, then I will not have to be on-call more than 16 times a year”* (EDC 1). The ICU consultants displayed greater caution regarding the affect of the CROC on their work-life balance, especially as a rota had not been designed: *“I would think that in terms of work life balance my hours would be reduced...but it’s very difficult to know without knowing what the rota actually looks like”* (ICUC 4). If a positive work-life balance was to be achieved, then a rota needed to be negotiated, with the frequency of shifts approved by both consultants and management.

Job Satisfaction

For many of the ED consultants becoming a CROC and having the opportunity to focus on trauma care was something they were particularly interested in and they anticipated that their job satisfaction would improve by advancing their interests and personal development; *“One of my main areas of interest is trauma, so I am looking forward to this...it’s just going to lead to my personal development...it’s personally very exciting for me” (EDC 1)*. The MTC and the specific job plan associated with the CROC could also mean the trauma consultant role would be seen as more credible by other consultant specialties, something they may not have experienced previously. ED consultants added that knowing that they were providing the best possible care would make the role satisfying. Having an interest in trauma was not exclusive to the ED consultants as some ICU consultants also expressed excitement at being able to work in a role usually undertaken by ED staff:

“This is one of the few places I have encountered with a big interest in major trauma. I’m going to get to go out and lead the trauma team...in some places ICU is relatively passive...so being able to do that is great for me” (ICUC 7).

There is a common assumption that when an employee is satisfied with their role, this leads to improved performance and consequently improved organizational outcomes. This stems from the premise that attitudes have behavioural implications, and if an attitude is evaluated favourably, then individuals will engage in positive behaviours to support it (Judge, Thoresen, Bono & Patton, 2001). Consequently roles that lead to improved job satisfaction could have an indirect positive impact for patient safety and service quality.

Interviews with ICU consultants also suggested that the CROC could lead to increased job satisfaction, but this was linked to the level of remuneration (financial and in terms of time-off compensation) they would receive: *“There is a good locum rate, so a bit of extra money frankly is quite welcome to a lot of people”* (ICUC 3). In this way, satisfaction was partly related to the employment relationship and the extrinsic satisfaction associated with the development of the new contract. This suggests that some ICU consultants viewed the CROC as more transactional than their ‘official’ role, and in exchange for modifications to both their working role and hours, appropriate compensation was required. A few ED consultants also mentioned that financial remuneration could help improve job satisfaction:

“I certainly, and most of my colleagues want to do it (CROC) and feel that we will get job satisfaction from doing it, but only if it’s being done in a sustainable frequency and for a reasonable financial remuneration” (EDC 6).

Consultants had some perception of an exchange relationship with those implementing the MTC, and the increased job satisfaction could occur if they were treated fairly. This exchange relationship appeared to be transactional in nature – similar to that experienced by ‘traditional’ temporary staff, even though the consultants were full-time employees. When undertaking the CROC, a new ‘deal’ was forming.

Satisfaction was also associated with the CROC accommodation. Materson et al., (1994) had previously discussed the importance of on-call accommodation for job satisfaction. A consultant stated: *“The intensity of the work is not too onerous, so long as adequate rest facilities are provided...I mean a quiet private room with a bed in it. Then I see no objection to twenty-four hours on call”* (ICUC 5). Once again,

there was an element of a new ‘deal’ developing between the consultants and management. The consultants had no objection to the principles of the CROC. However for consultant satisfaction, necessary facilities needed to be provided and were expected as part of the contractual agreement.

Impact on Other Hospital Staff

Patient safety could be improved through the impact the CROC has on other staff involved in trauma care. ED and ICU consultants discussed the potential positive implications for junior doctors. Some argued that having a continuous consultant presence would provide junior doctors with learning and training experiences in trauma management, as junior doctors could approach the CROC for trauma care advice. Junior doctors could also have greater exposure to and experience of major trauma management:

“I don’t think it will detract from our juniors’ learning experience, if anything it will benefit them...I expect to be there with my juniors...sometimes advising them, sometimes leading them...it’s a great learning experience for our junior doctors” (EDC 1).

ED consultants mentioned the impact the CROC would have on other ED staff, for example the nurses who may be involved in trauma would have a greater reassurance about what is occurring when a trauma case enters the department, thus the care would be given in an increasingly timely and structured manner:

“Other members of the trauma teams will hopefully feel that they have a stronger management of the patient resuscitation, they know who is in charge and they know who’s making the decisions, they know that person is experienced...” (EDC 6).

This potential positive impact was discussed primarily by ED consultants, as the ED (the first point of call for trauma patients) had been described as being overstretched and under time pressures. Thus any intervention that could have a positive impact for staff was perceived as beneficial.

Impact on Other Patients

The potential for improved patient care for non-trauma patients was discussed. Consultants from both specialties suggested the improved governance and patient pathways developed for trauma patients could have knock on improvements for other specialties if similar approaches were applied across acute medicine. The enhanced level of communication between the two specialties (through the interdisciplinary trauma meeting and joint specialty working) could allow for the development of other communication channels, meaning patients could be transferred to appropriate hospital departments more quickly, resulting in improved timeliness of patient management: *“I think that there will be knock on effects for other services...as I said communication between departments and improving other patient pathways...but I hope that will carry on filtering through to other specialties”*(ICUC 1).

In summary, the consultants recognised the potential for developments in patient safety and service quality indirectly through the launch of the MTC. Quality of working life, in this study, broken down into work-life balance and job satisfaction (both intrinsic and extrinsic), could be enhanced, potentially improving job performance and outcomes. However, a positive outcome was only thought possible if the CROC was successfully implemented and if the changes to their job plan were appropriately compensated (both financially and with time off), indicating a transactional exchange relationship when undertaking the CROC. Patient safety and

service quality could also be improved through the impact on other hospital staff, and the development of acute medicine care pathways based on major trauma care plans.

6.7.2 Pre-Launch Analysis of Potentially Negative Effects on Patient Safety and Service Quality

Although the analysis of consultant pre-launch interviews suggested the CROC could be positive for patient safety and service quality, there were also concerns that the change in work pattern could lead to potential negative outcomes for patient safety and service quality.

Figure 2 displays results from the thematic analysis of consultant pre-launch interviews, indicating how the CROC could have negative implications for patient safety and service quality. What became clear was that not only were there concerns about how the CROC could potentially clinically impact patient safety and service quality, but how the management and consultation of the launch could affect their employment relationship, their quality of working life and their morale.

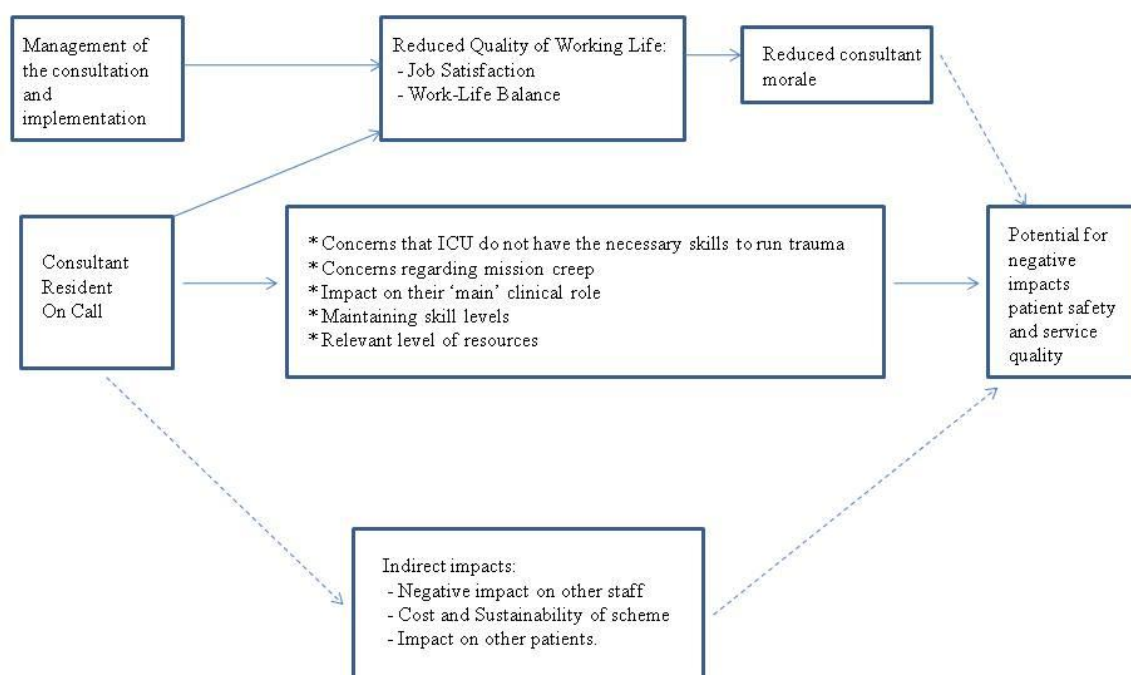


Figure 6.2: Pathways indicating how patient safety and service quality could potentially be negatively affected by the launch of the CROC.

6.7.2.1 Direct Pathways for Reducing Patient Safety and Service Quality

Concerns regarding ICU staff and skill levels

The unique joint specialty staffing model for trauma care at hospital A, resulted in concerns regarding whether this would be beneficial for patient safety and service quality. Both ED and ICU consultants voiced anxieties regarding ICU consultants leading trauma cases, predominantly about whether they had the necessary skills to manage trauma patients – what some ED consultants described as the most taxing element of the ED role. If consultants did not have the appropriate skills, this raised questions about the principle aim of the MTC to improve trauma care:

“I think that there are a small minority of the Intensivists who do have the expertise in initial trauma resuscitation, but the majority of them don’t...I find it quite unreasonable that Intensive Care consultants think that they can pop down to the Emergency Department and would do one of the most taxing aspects of my job” (EDC 6).

ICU consultants were concerned that they had insufficient training in ED medicine and may not have the skills to conduct the most dramatic procedures necessary for trauma care and could not be considered as trauma experts at the ‘front-end’ of trauma care delivery:

“I have concerns about a job that seems to me to be a job for an A&E consultant...I don’t really feel that’s what I am trained for and I have concerns about trying to do a job which other people trained for, for six years...my concerns about this is really that this is a job for which I’m not trained” (ICUC 2).

If the aim of the MTC is to provide trauma patients with expert care, it could be perceived that having ICU consultants on the rota may not be appropriate. Some ED consultants expressed the desire to have the trauma rota covered solely with ED staff, but recognised that financial constraints preventing the recruitment of further ED consultants meant this was not possible.

Major trauma training was offered to ensure all staff were sufficiently trained for trauma care. However, for various reasons those who needed the training may not have undertaken it – one of the main issues being the time needed for the course: *“I would need to be retrained a little bit. But one of the issues is that I physically don’t have the time for training...” (ICUC 4).* Some consultants argued that if all

consultants were to be at the same competence level so that patients receive the best possible care, then trauma training must be undertaken by all potential CROCs.

In conjunction with trauma training, ICU consultants mentioned skill maintenance, especially if trauma was infrequent. Consultants were questioned about the prevalence of major trauma pre-MTC launch, and although there were some debates as to what actually constitutes 'major trauma', consultants reported that major trauma was 1 percent of the ED throughput. Some consultants believed that would increase post-MTC launch; however, others stated that hospital A already received a large proportion of trauma cases in the area. Anxieties regarding skill maintenance were connected to the occurrence of major trauma and the frequency of being the CROC:

"I do actually worry...it turns out not to be that busy, so you do a 24 hour shift and you only see one major trauma in 24 hours...but if you are only doing that 1 in 8 or 1 in 10, you don't actually see that many. So even within that, how do you maintain a level of skill?" (ICUC 2)

A small proportion of the consultants mentioned the impact that the CROC would have on their 'main' clinical role. ICU consultants in particular noted that working on a split rota could lead to an element of skill dilution in both roles, although once again, this was dependent on the frequency of undertaking the CROC.

ICU consultants added further concerns, about their suitability to undertake the role themed around their limited knowledge of the ED environment, where equipment was kept, not knowing the team they would be in charge of managing and the difficulty in developing relationships and understanding the working patterns of the team, questioning their ability to work to the standard required for a MTC:

“...You’re leading a team of people, some of whom you don’t know that well...working in another department is always potentially difficult in human factor terms...there are risks in terms of team leadership. It is their department...they do perhaps work differently” (ICUC 7).

This highlights the importance of the trauma team leadership training that was being developed, but could add more credence to the argument that the CROC should be solely an ED consultant role, to reduce any risks associated with unfamiliarity of roles, environment, skills and personnel.

These arguments echo those discussed in Chapter 3 relating to temporary staff in healthcare – in that subtle differences in unknown work environments (both human and physical) could lead to errors in patient care (Audit Commission, 2001; Fitzgerald & Bonner, 2007; Krogstad et al., 2002). Although in this study, the ICU consultants were not external to the hospital, they did come from a different specialty, where different skills and protocols were used, and their interaction with ED staff may be limited. The ICU consultants would be effectively ‘locuming’ in the ED (an unfamiliar environment) for the duration of their CROC shift – leading to concerns (from both specialties) about trauma patient care.

Mission Creep

Both specialties raised the subject of ‘mission creep’ – being asked to help out in the ED when they were the CROC, going beyond the realm of the service the major trauma consultant is to provide. This was a greater concern among the ED consultants, as they had an increased likelihood of being recognised in their own department. The anxieties centred around the idea that if the ED was particularly busy, and struggling to maintain waiting time targets, they would be asked to help

with non-trauma patient care – potentially becoming distracted from their trauma role, and disturbed throughout the night with ED cases:

“...In reality the trauma consultant who is on during the day will be seeing other patients in Resus...that’s not the role, and if that role is to be extended to us unofficially in the night, when the ED consultant on-call has gone home, and I’m seen here, then in reality I will be up all night” (EDC 2).

This increases the likelihood of patients being treated by over-tired doctors, potentially resulting in negative patient safety and service quality. Mission creep highlighted the importance of developing a clear job specification and being compensated correctly for the work they would be undertaking, indicating having to develop a new ‘deal’ for the CROC.

Resources

Consultants questioned whether the necessary resources were in place for the MTC, both in terms of the number of consultants prepared to undertake the rota and the physical resources, in terms of a trauma room and other facilities necessary for successful trauma treatment: *“I do not believe that (the hospital) is ready to become a Major Trauma Centre...we do not have the personnel to provide it, we do not have the physical infrastructure to provide it...”(ICUC 6).* During the pre-launch interviews it transpired that ICU consultants who had originally been willing to undertake the CROC had opted out in response to funding cuts limiting the resources to be given to the department for participating in the MTC: *“We know that a large number of the Intensivists have dropped out...the upgrade of Intensive Care has been put on hold due to financial cuts and they pulled out” (EDC 6).* This led to concerns about whether hospital A was ready to become a MTC, what affect this

would have on patient safety and service quality, and the implications on the new ‘deal’ perceived by the consultants.

In summary, although the consultants recognised the MTC was essentially a good initiative, the manner in which it was being launched could have negative repercussions for patient safety and service quality, especially when considering the suitability of having consultants who may not be sufficiently experienced or appropriately trained for trauma and inappropriate/insufficient resources available.

6.7.2.2 Indirect Pathways for Reducing Patient Safety and Service Quality

Indirect pathways through which patient safety and service quality could be negatively affected were also identified.

Management of the Consultation and the Launch

A prominent theme throughout the pre-launch interviews was disappointment in the management of the consultation and launch of the MTC, negotiations over the nature of the role and the terms and conditions of the CROC contract. Consultants had not seen a suitable or sustainable rota and were unwilling to sign up to a change in work-plan until they knew the frequency of CROC shifts:

“I am willing to participate in a potential rota but one of the difficulties is obviously at the moment the rota isn’t agreed yet, the format isn’t agreed, so it’s quite difficult to fully commit to something that isn’t really completely presented to me” (ICUC 4).

The frequency of undertaking the CROC was related to the number of consultants willing to take part in the scheme. There was little knowledge about contingency

plans in place to cover sickness, annual leave or to prepare for succession planning. The uncertainty about the change to work plans and working hours were not the only issues of contention – the job specification and how the CROC would be operationalised was still under discussion. Consultants were unaware of what their new role would involve, and were unwilling to sign contracts until they had clarity regarding what was to be expected of them:

“At the moment I am just a bit wary about what this new job plan is going to be...We haven’t signed any contracts because they haven’t told us what the contract’s going to be, you know, they haven’t given us a job spec, so I guess that’s going to be fundamental to what we do” (EDC 2).

This indicates a transactional relationship on the part of the consultants – an unwillingness to formally agree to become a CROC until the nature of what is to be expected of them has been confirmed. The absence of any firm decisions left many of the consultants feeling unsettled and misinformed undervalued and questioning whether they will actually take part in the rota:

“You expect some respect and that isn’t forthcoming...because of their continued lack of interest we’ve actually reached a point where we’re like, if you don’t want this then fine, we’re not going to do it” (EDC 5).

Compensation for being resident overnight was also discussed. The consultants were uncertain about the level of financial remuneration and time compensation the hospital would offer for the services they would be providing, and would not become CROCs unless what they deemed to be a sensible offer was proposed. Although the consultants were concerned about the final ‘deal’ and what their new role would involve, they were also aware that the changes to their working plans during the

interim phase was a concern, and there was an expectation of fair treatment throughout the process leading to the eventual new 'deal'.

Throughout the pre-launch interviews, some ICU consultants pulled out of the scheme, the trigger being that the offer made to them by management was unsatisfactory – in terms of the on-call facilities and the resources offered to the ICU department. An ED consultant stated hospital A should deliver an attractive package, effectively having to convert the consultants to undertake the CROC, as they had reached a stage where they were prepared to walk away from the scheme. The 'derisory comments' made by management towards the consultants throughout negotiations were considered as an appalling way to treat staff.

Management's communication of the proposals was often discussed. One consultant described the consultation process as an ultimatum, similar to being served a court order. Another added that consultants should not feel 'forced' into the scheme, and that an antagonistic negotiating style had been adopted by management. There were perceptions from consultants in both specialties that they were misinformed about decisions being made, and due to the 'opaque' management style, there was little sign that anything was actually occurring:

"...There's been a terrific esprit de corps amongst the people at consultant level. It's above that level that it all suddenly gets murky...they refuse to comment on what's actually happening...the leap between the consultant body and the upper echelons of management has been less than ideal"
(ICUC 6).

The perceived lack of communication between management and the consultants led to the opinion that information was becoming distorted. A consultant from both

specialties had been nominated to represent consultant views to the managers, although there was little information regarding how they were chosen, how frequently they met and how representative they were of the CROCs. The miscommunication seemed to indicate a lack of respect for consultant well-being, resulting in frustrations that they were being ignored.

Work-Life Balance

Both ED and ICU consultants mentioned how participating in the MTC could be disruptive to their lives outside of work, as the CROC would increase the number of anti-social hours worked: *“Nobody particularly wants to or enjoys working nights”* (EDC 3). However, the importance of correct management of the remuneration was highlighted, as the financial package was considered as compensation for the disadvantages of working at night (being tired the following day, and disrupted sleep patterns). The rota could have increased the number of weekends the consultants would work, having a large impact on their lifestyle. If the rota was implemented as it had been proposed, consultants would be entitled to the following day off, having worked overnight. However, some stated this day off would not necessarily be productive, as a result of disrupted sleep patterns, and a more disordered life: *“I will have more days when I am tired and am essentially napping on the sofa. I will see my friends and family less and I will have a more disordered life”* (ICUC 5).

However, when the pre-launch interviews were conducted the rota had not been agreed and the consultants were unclear about the true extent of the impact of the CROC and its implications for their work-life balance. This element of uncertainty was itself a source of disruption as consultants were unable to plan annual leave or other out of work activities:

“Everything seems to be up in the air and it’s very difficult to organise the rest of your life if you don’t know exactly what you’re going to be working at in six months time” (ICUC 2).

Both specialties were aware that the CROC was not a role they could maintain for their whole career and their ability and willingness to become a CROC was dependent on age. Consultants were conscious that the older you were the more disruptive sleepless nights would be for your body clock and could lead to potential burnout – an obvious risk to patient safety. This issue highlighted the importance of hospital A having succession and contingency plans in place, which at the time of the pre-launch interviews had not been considered.

Consultants from both specialties discussed the impact the CROC would have on non-clinical hospital roles. Consultants remarked that any ‘free-time’ gained as a result of being a CROC would be used to complete other roles (for example, paper work, research, writing new protocols, training), and the hospital would not appreciate this, especially with the pressure to maintain high standards:

“What will affect my personal life is the stresses that may be involved in trying to deliver the other roles as a consultant and taking back the stresses from that...I will be doing longer, unpaid hours to make sure those roles are completed” (EDC 2).

Job Satisfaction

Respondents discussed how the change in role could affect their job satisfaction. ICU consultants commented on how the role would be completely new to their clinical practice - a fundamental change to the nature of their work, resulting in the consultants working outside their comfort zone in a role they may not particularly

enjoy: *“I have limited interest in trauma...I didn’t train to be an ED physician and I remain having very little interest in that...it would negatively impact on job satisfaction and motivation” (ICUC 1).* ICU consultants discussed working in a position they were not fully trained for, taking time away from a role they enjoyed, which they considered to be detrimental to their job satisfaction, having a potential negative impact on patient safety and service quality: *“You’re going to be very half-hearted doing something that you don’t really want to do and you’re worried you’re not trained for” (ICUC 2).* ED consultants understood that this would be a greater clinical role change for ICU consultants; subsequently there was little surprise that they could get reduced satisfaction from undertaking the role.

In comparison, hospital C stated that individuals should not have to undertake roles they were unhappy with – whether this was in a trauma capacity or not. The hospital worked on the principal that: *“If you’re forced to do something you have no interest in, you won’t read about it, you won’t learn about it...you will end up withdrawing to a greater or lesser extent” (Hospital C).* At hospital C they understood that if the workforce was managed appropriately and had the motivation to undertake the trauma role then everybody would work with the same mentality, all prepared to undertake service development, so patient care would be of the same standard at all times. In this way, changes to a previous role or the need for a new deal were limited, minimising any risks to patient safety.

Both ED and ICU consultants at hospital A described poor morale resulting from a lack of respect from the hospital, and felt insulted that they had to negotiate their contracts with management. The uncertainty of not knowing the job specification, or when the new rota would be implemented created dissatisfaction: *“I think that any uncertainty in a job that is very pressurised anyway, I don’t think it takes very much*

to actually tip us into a sort of despair really” (ICUC 4). Consultants were wary about the impact on their workload, and how this would affect job satisfaction. There were concerns that the ED was already understaffed and overworked, and adding the CROC would make the consultant role unsustainable. When asked what the consequence for patient safety and service quality would be, a consultant replied:

“You get people who just aren’t happy at work, come in and have a bad day and lose motivation to do their job. You have people who are so worried and stressed about the future of their job and their career that they actually become poor decision makers” (ICUC 5).

The uncertainty, reduced morale and impact on job satisfaction were often mentioned in conjunction with poor consultation and lack of communication from management.

Impact on other staff

Other indirect ways in which patient safety could be affected by the CROC were identified. Both ED and ICU consultants were concerned about the impact on junior staff. Although, some had argued that the CROC could result in increased learning opportunities through having consultant experience readily available, others believed that consultants could detract from the junior doctor’s hands-on experience, minimising their training experiences. The CROC was introduced to provide senior expertise to trauma patients; however concerns centred on how the CROC would affect the junior doctor’s ability to run trauma in the future when they reached consultant level, if their hands-on experience was limited:

“The more that we are there as a consultant, the less opportunity they have, which means they are less experienced when they become a consultant...we

need to be cognisant of the fact that their training needs need to be met as well” (EDC 3).

Alongside this, the mandated time off after the over-night residency meant that meeting with junior doctors to discuss supervisions would be difficult to arrange. ICU consultants voiced concerns about training junior doctors from the ED when they were leading the trauma calls, especially as they were unsure about undertaking some of the trauma procedures themselves.

ED consultants were increasingly aware of the impact that removing a consultant from the ‘shop floor’ to specifically cover trauma patients could have on other members of staff in the ED. Having a CROC (concentrating on a few patients) would result in fewer available ED staff to provide general patient care, increasing the pressure on already busy ED staff. This was compounded by the knowledge that the ED was not recruiting additional consultants. Implications for ED nursing staff were also considered – associated with concerns relating to unknown ICU CROCs working in the ED, and building team relationships with them so that major trauma care ran smoothly:

“...Issues for nursing staff have not yet been addressed...how they will feel having another specialty come into the department, they haven’t really met and built relationships with yet...this may potentially be quite difficult over the first few months” (EDC 3).

ICU consultants discussed the impact of being away from their department, and how this could affect their relationship with ICU staff and reduce the continuity of care provided by the ICU team, mirroring concerns discussed in the literature regarding the impact of temporary staff on team relationships (e.g. Lundstrom et al., 2002).

Cost of CROC and impact on other patients

Both ED and ICU consultants thought the CROC placed too much emphasis on trauma patients (approximately 1 percent of the ED throughput) and there was need for a greater balance for the other specialties in acute medicine: *“It seems to be a disproportionate amount of time spent on managing a very small number of patients...other areas of hospital life that really seriously need to be addressed aren’t being addressed” (ICUC 1).*

The cost of the CROC was discussed, with consultants reporting it was not cost-effective to pay senior staff to cover a small proportion of patients, and it would be more efficient to use hospital funds to develop the support services and patient pathways that trauma patients would use. The idea of auditing what the consultants do when working as the CROC was suggested, especially if the role did not appear to be financially sustainable. Others proposed that if patient pathways were properly and formally organised there would be no need for a CROC, while others thought the CROC formalised trauma care procedures already in place. The cost of the CROC was discussed in relation to its efficacy and whether the consultant presence was the reason why trauma care had improved in the MTC’s reported in academic literature:

“If I was drawing up the designation criteria myself, I’m not necessarily sure that’s where I would put all the money...whether that (CROC) has actually been teased out as being the element that provides benefit, I’m not aware I’ve read that it has actually shown that...” (EDC 3).

In summary, the management of the MTC/CROC launch, with its lack of communication, contract and role specification resulted in the consultants feeling uncertain about how their work-life balance will be affected, and a reduction in the

morale of the staff involved. This could have negative implications for patient safety and service quality, negating the aims of the MTC. Consultants also questioned the cost of the scheme (which seemingly helps only a minority of ED throughput) when other patient needs may not be considered as important. The results indicated a change in the employment relationship between hospital A's management and the consultants when discussing the CROC role and the new 'deal' associated with it.

6.7.3 Pre-Launch Interview Findings Summary

The analysis of the pre-launch interviews suggested the aims of the MTC to provide 24 hour consultant presence should ultimately improve patient safety as a result of the high level experience provided. Consultants noted that the dual-specialty model would improve communication between the two departments, allow for the development of patient pathways and improve the timeliness of patient management. The launch of the MTC also meant that training opportunities were introduced to develop trauma skills. ED consultants voiced concerns in reference to the use of ICU consultants undertaking the most demanding aspect of their role, especially if the opportunities to develop trauma skills were not realised by CROCs.

The CROC required a change in work patterns for the consultants involved. For the twenty-four hour cover to be realised, consultants were to be compensated with time-off before and after their CROC shift, beneficial to the work-life balance for some consultants. Others felt that the CROC would encroach into their family life, free time and increase the number of anti-social hours worked. However, the full work-life balance impact could not be determined as rotas had not been negotiated.

The change in role that becoming a CROC necessitated was perceived to be greater for ICU consultants, who would effectively be working as a locum in the ED, and some ICU consultants thought they may not enjoy the role. Conversely, ED consultants expressed satisfaction at the opportunity to become a CROC, as being able to look after seriously ill patients would be intrinsically beneficial for them.

Consultants from both specialties expressed frustration in the management of the CROC launch and negotiations. There was uncertainty about the job specification, and how frequently they would have to work CROC shifts and as a result were unwilling to sign contracts. To ensure the MTC was launched on time as mandated by Healthcare for London, the consultants were employed as locums, working voluntary additional hours (on top of their substantive role), and receiving locum payments when undertaking the CROC pending contractual agreements. Management were proposing that consultants were to commit to sixteen twenty-four hour shifts over a twelve month period, with appropriate rest requirements and facilities. However, as management had not provided any contracts, rotas or what the consultants perceived to be appropriate facilities, the locum arrangement was going to be used until a new deal was arranged.

The pre-launch interviews provided some examples of a transactional employment relationship often associated with temporary employees; for example, the consultants wanting full remuneration for their change in working hours, both in terms of financial and time remuneration (considered important for their job satisfaction). A number of ICU consultants decided not to participate in the rota when some of the benefits to their department initially associated with the MTC launch were not being introduced, indicating a breach in consultant expectations. There was an

unwillingness to formally agree to the CROC until the nature of the role and suitable work plans had been confirmed.

Consultant apprehensions regarding the CROC were based around the competence of ICU staff, the impact on other staff, the impact on non-trauma patients, the content of the contract, their quality of life and job-satisfaction and management behaviour.

The second stage of the study involved a second round of interviews. All consultants were once again invited to take part, including those hired to take part in the CROC since the MTC was launched. A Clinical Director from both specialties at the hospital involved in the management and development of the CROC were also interviewed post-launch, providing insights into the managerial decisions and processes involved. The findings from this stage are presented below.

6.8 The Impact of the CROC Arrangements on Staff and Patient Safety: Post-Launch Interview Findings

The following section presents findings from interviews conducted with the consultants post-MTC launch. Interviews were conducted between 8-10 months post launch (10-12 months post pre-launch interviews), the time variation due to availability of the consultants. The section also includes findings from two other London MTCs. At the time of the interviews, consultants were still working on a locum basis, and consequently final numbers 'signed-up' to the CROC was unknown. Results focus on how the management of the CROC launch influenced

the nature of the exchange relationship between the consultants and management and the implications for patient safety and service quality.

6.8.1 Positive Impacts for Patient Safety and Service Quality

This section presents the analysis of post-launch interviews focussing on how the management of the CROC resulted in positive patient safety and service quality. Consultants provided examples of critical incidents when the presence of a CROC led to positive patient outcomes. The analysis also suggested that there were indirect pathways to positive patient safety.

Figure 3 displays the results of the thematic analysis for the post-launch consultant interviews, indicating ways in which the launch of the MTC and CROC was perceived by the consultants to result in positive outcomes for patient safety and service quality. Having a CROC was described as clinically beneficial for patient safety. However, benefits to patient care were also discussed in relation to improved quality of working life.

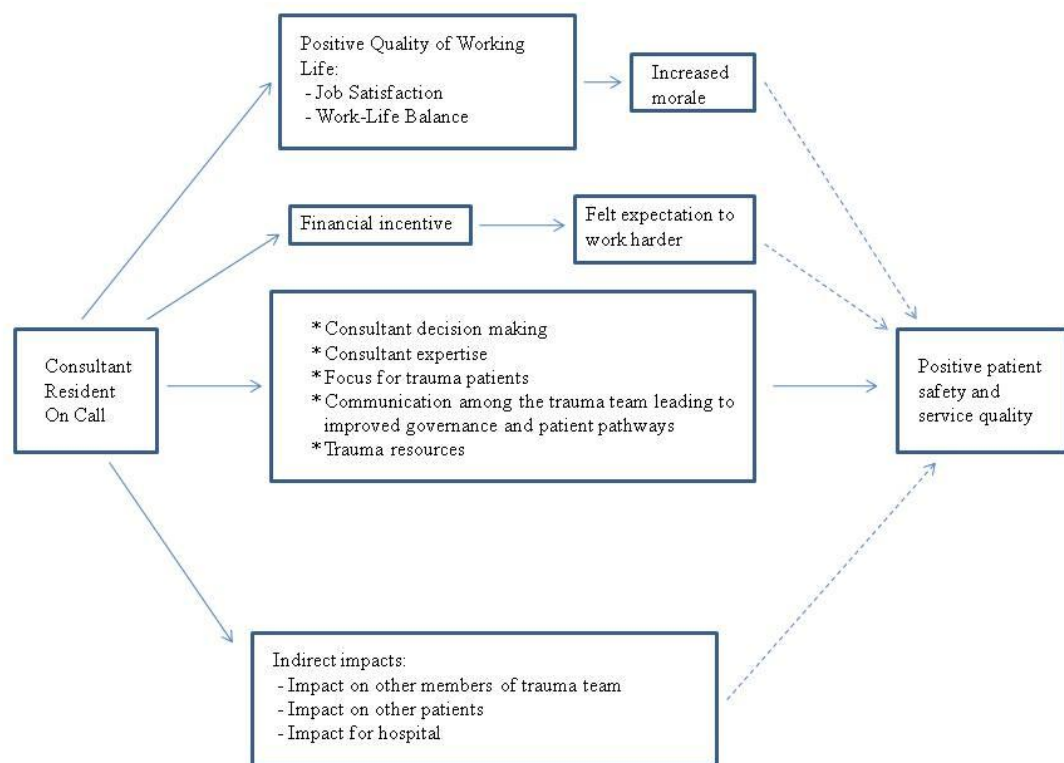


Figure 6.3: Pathways indicating how patient safety and service quality is perceived to have improved post-launch of the MTC and the introduction of the CROC

6.8.1.1 Direct Pathways for Improved Patient Safety and Service Quality

Consultant Decision Making

One of the main aims of the MTC was to improve the time from injury to treatment of trauma victims, increasing chances of survival. Both ICU and ED consultants discussed how the CROC allowed for patient care and treatment decisions to be made more speedily as they facilitated and co-ordinated patient care appropriately:

“Having a consultant in Resus does speed up the process. We get the imaging done, we send the patients for a scan if need be, we make very quick

triage decisions...those patients are not delayed when they go out of Resus, so I think it has speeded up the actual mechanics of the process” (ICUC 1).

Having a consultant making decisions meant trauma teams became more efficient, resulting in less time wasted in patient diagnosis. As part of the designation criteria MTC’s collected and submitted trauma data through the national Trauma Audit and Research Network (TARN) database. There were specific inclusion criteria for patient data to be submitted including: admission to Intensive Care, death during admission and transfer to specialist care. Some consultants discussed the CROC in relation to the audited TARN data: *“We have as a hospital, had unexpected survivors...early decision making definitely has been shown in the data that we’ve been auditing...” (EDC 3).* Others added that decision making and the timeliness of despatching patients to the CT scanner (the CT scanner was described as key in the diagnosis of major trauma patients) had improved, resulting in positive patient outcomes.

The London Trauma Office, the board overseeing the ongoing development of the Trauma System, and co-ordinating the overall performance management of the Major Trauma model (London Trauma Office, 2011, page 2), produced a report that charted the progress of the London Trauma System after its first year. From data submitted to TARN, the report acknowledged the time taken from entry to being scanned, in hospital A had reduced from 1.3 hours pre-MTC to 1 hour post-MTC launch. In critical incidences described by consultants, the consultant’s presence in making timely decisions and the ordering of scanning and treatments was perceived to have a positive affect for trauma patient outcomes.

Consultant Expertise

The majority of consultants interviewed post-launch discussed the importance of consultant expertise when treating trauma patients:

“You do need a consultant there because there’s a massive step up between being a trainee and a consultant...all the evidence does suggest that in emergency care, if there is a consultant present it has an impact on outcome, a positive impact” (ICUC 4).

The consultants suggested they have a better understanding of the processes involved in trauma care, were quicker in determining the course of action and were able to think more laterally about the patient’s care pathway instead of focussing on one problem. Added to clinical expertise, consultants also mentioned the importance of having a cultural awareness of the hospital:

“The very complicated patients do require a degree of institutional personality knowledge to actually navigate and to get the patient through the system, but it is actually difficult for a junior to be empowered to do so” (EDC 3).

After the launch of the CROC, it was thought that not having that resource or removing it (as a result of the cost to the hospital, or if an audit of the London Trauma System indicated that 4 MTCs in London were too many) would be a retrograde step and detrimental to patient care.

Focus on Trauma Patients

Having a specified consultant for trauma patients meant consultants were able to solely focus on treating trauma patients without having to switch focus to other ED

cases. Being able to treat a patient with fewer distractions was viewed as a distinct improvement to patient safety and service quality: *“Whenever I am on for major trauma, I can focus and really give my energy to the major trauma case, without having to be pulled away to look at other patients” (EDC 2)*. Previously, when traumas arrived at ED, it would have been difficult to concentrate solely on them, especially if the consultant was on-call to cover the rest of the ED. This specific focus for trauma care was considered to be beneficial. However, the level of trauma calls within shifts was variable. Consultants reported that weekday shifts could receive between 4-7 trauma calls within the 24 hour period, although, not all of these required the trauma consultant. The level of trauma was reportedly higher at weekends.

Communication in Trauma Team

A number of improvements in communication were discussed as a result of the CROC. The decision to have joint specialties led to improved communication between the two departments, better working relationships, and the opportunity to learn skills from each other. The opportunities for dual-specialty communication, seen during the multi-disciplinary team meeting every morning, discussing the care for trauma patients from the previous 24 hours meant that patient protocols and pathways could be improved and developed. The Clinical Director for the ICU and ED also discussed the dual-specialty model with reference to improved relationships and dynamics between the two departments when dealing with trauma patients and their care pathways. This improved communication between specialties was viewed as a benefit of employing in-house staff as CROC's:

“...The relationships between ED and ICU, that's improved, but I would say one of the major improvements is ICU and Radiology, that has improved

vastly and that's been a really powerful and important relationship to build"
(CD, ICU)

A few consultants recognised it was difficult to measure quantitatively the impact of these improved communication channels, but it was perceived to be beneficial for patient safety. The seniority of a consultant running trauma led to consultant-consultant communication occurring more frequently, meaning: *"Speeding up the process, made it safer, much better governance, more protocolisation, more discussion and it is breaking down the silo barriers"* (ICUC 1). This reduction in delays allowed for patients to be scanned and diagnosed within official trauma targets, and consultants mentioned that data audited thus far suggested the targets were being met. The communication between different departments, and the major trauma team (especially the improved communication between radiology and general trauma surgery) was specifically mentioned in a critical incident, aiding the immediate flow of patient care plans and transfers in the hospital resulting in faster treatment.

Trauma Resources

To enable better access to trauma care and to meet the designation criteria, extra resources were necessary for hospital A. The purchase of a CT scanner was considered very important for patient safety, as it provided diagnostic tests that positively affected timings for patient care. There were moves to further improve the timeliness of patient care by integrating the CT scanner into 'Resus', reducing patient transfer times. Although the CT scanner was used primarily for trauma patients (and trauma patients had priority), other patients also benefited from the CT scanner for diagnosis.

Others mentioned increased human resources, such as an increase in nurses to help with patient load in the ED and an extra radiologist overnight. It was recognised that further resources were needed to improve patient management (such as increasing the capacity of Critical Care, Resus and the development of a specific Major Trauma ward), but this required increased funding, and some consultants questioned the cost of MTC resources which only benefited a small proportion of the hospital's throughput.

In summary, the CROC (although still undertaken on a locum basis) was thought to have improved patient safety and service quality by providing expertise and management to trauma patients, aided by the addition of both human and physical resources. Consultants provided clinical examples of when they believed the CROC resulted in patient survival despite the serious nature of their injuries. Representatives from hospitals C and D cited similar reasons why the CROC benefited trauma care, both discussing the importance of consultant knowledge, experience and authority to make the necessary decisions in the time available and co-ordinating a team consisting of a range of specialties. Having a consultant present added a level of consistency to the care provided, especially as the trauma team was variable. Hospital D's interviewee also mentioned being labelled the 'Trauma Consultant' provided more credibility to the role, as, *"There is something about the hierarchy in medicine that expedites the process"* (Hospital D).

The London Trauma Office (2011), reported results for all of the MTC's in London using data submitted to TARN. In its first year, the MTC at 'hospital A had an increase of 333 TARN recordable patients (from 252 pre-MTC launch to 585 post-MTC launch), of which 153 had an injury severity score classified as a major trauma. Between the 4 London MTC's there had been 58 unexpected survivors. At hospital

A specifically, the report noted other improvements to patient care including: monthly mortality and morbidity meetings promoting education and development, weekly open forums for teaching and education, and meetings/ward rounds to support the development of a patients ongoing care needs.

6.8.1.2 Indirect Pathways for Improved Patient Safety and Service Quality

The post-launch data analysis indicated the CROC could positively influence the quality of working life of the consultants. However, an unexpected outcome of the financial compensation for being the CROC was also mentioned, and this will be discussed in the following section.

Work-Life Balance

For some, becoming a CROC was beneficial for their work-life balance as a result of the required time off after the mandatory over-night stay, allowing the opportunity to undertake other activities or research. For a small number of consultants it meant: *“I actually work far less anti-social hours now, out of hours, weekends, nights, than I did as a trainee. So it has improved my life enormously” (AC)*. For others, the impact on work-life balance was unknown, as consultants were still working on a locum basis and with the flexibility to choose their CROC shifts. However, this locum period worked in their favour, allowing the consultants to consider whether they enjoyed the role (and if they wanted the role permanently). The positive effects for work-life balance were not as a result of the locum contract per se, but as a result of the change in working hours necessitated by the CROC.

Job Satisfaction

For the ED consultants and the consultant Anaesthetist (invited to be a CROC because of their extensive trauma experience), working as a CROC was a role they found interesting and enjoyable in terms of the clinical challenges they faced, and the opportunity they had for professional development: *“My learning curve is up. This is the thing that I enjoy doing and the thing I went into medicine to do” (EDC 2)*. Having the opportunity to focus on a specific patient allowed for continuity of patient care, and the knowledge that there were more unexpected survivors provided job satisfaction. A number of the ICU consultants stated the CROC provided them with an interesting challenge, dealing with the patients as soon as they entered the hospital (as opposed to their usual contact with trauma patients in critical care wards) and the opportunity to develop new clinical skills: *“It’s been a fantastic opportunity...it’s been great for me to have been involved at the front door” (ICUC 3)*.

Implications of Financial Compensation

For many, job satisfaction was seemingly connected with the financial compensation given to the consultants as a result of working on locum contracts. When consultants undertook the CROC during the locum period, they were paid £130 per hour overnight (from 5pm until 9:30 am), in addition to their substantive consultant salary. However, in exchange for this level of pay, consultants felt they should take on extra duties not associated with trauma care when working as the CROC, especially if the ED nurses seemed under pressure, as consultants were paid per hour what ED nurses were paid per shift:

“Because we’re being paid extra to do it, there’s a bit of pressure on you to do things which aren’t really part of the role...the A&E Consultant might be

trying to keep the department under control, they're short staffed on the medical and nursing staff, and we're being paid extra (it's hard) to turn around and say I'm going back to bed now" (ICUC 2).

This could be seen as positive for non-trauma patients who would be treated more swiftly. From a management perspective, although this was currently working in favour of hospital A, caution was expressed by the consultants regarding whether this good will would continue when contracts were finally agreed, and the CROC was no longer paid at locum rates.

Other Indirect Positive Pathways

The CROC leads a multi-disciplinary trauma team when delivering trauma care. Half of the consultants interviewed discussed the positive impact of the CROC on trauma team dynamics, in relation to the definition of roles within the trauma team, providing clarity as to who was to conduct what element of patient care, resulting in more structured care. There was greater assurance that a team would respond appropriately to the trauma calls when being led by a CROC:

"Members of the trauma team behave better when there's a consultant there...people are a lot better at actually coming to the trauma call rather than just ambling along...they are far more involved and far more ready to be involved" (AC).

ICU consultants added that having a multi-disciplinary team aided the CROC if they were unsure of ED protocols – reducing the possibility of errors to patient care, highlighting the importance of skill robustness.

Half of the consultants (both ED and ICU) also mentioned improved care provision for non-trauma patients, with trauma patient care models being expanded to other patient pathways, and resources gained for trauma (especially the CT scanner) being used in non-trauma patient diagnosis. It was also mentioned that the MTC would secure future clinical services at the hospital.

Pre-launch interviews had suggested the CROC could have a negative impact on training for junior doctors in the ED. This was discussed post-launch by a minority of consultants who were encouraged by the experiences junior doctors were receiving through witnessing more trauma calls, and having the opportunity to lead them with full CROC supervision. However, letting junior doctors lead trauma calls even with the CROC overseeing everything seemingly went against the original aims of the MTC, and the mandatory CROC leading the service. Consultants added that developing the trauma model so trainees gain more experience was extremely important, especially when there were multiple trauma patients.

In summary, consultants discussed indirect pathways through which patient safety and service quality had improved. For some (generally the ED consultants), the role allowed for the development their interests in trauma, improving job satisfaction. The financial compensation made the role more appealing, and led to consultants feeling they should undertake additional duties in exchange. The following section discusses concerns relating to the management of the CROC and MTC launch, how this affected the 'deal' and patient safety and service quality.

6.8.2 Negative Impacts for Patient Safety and Service Quality

The consultants and the London Trauma Office report provided evidence suggesting that having a MTC and CROC led to an increased number of unexpected survivors and improvements in meeting targets for times of diagnosis and treatment. The consultants also expressed a number of concerns, ranging from the applicability of ICU consultants running trauma care, to the management of the launch, change in contracts and working hours, which at the time of interviewing were still on-going. Consultants did not provide any critical incidents describing when these negative impacts led to a reduction in patient safety, but there was the perception this could occur.

Figure 6.4 shows how the MTC launch had negatively affected patient safety and service quality directly and indirectly. Although evidence suggested that the MTC had improved trauma care, the management of the launch had implications for the employment relationship and the ‘deal’.

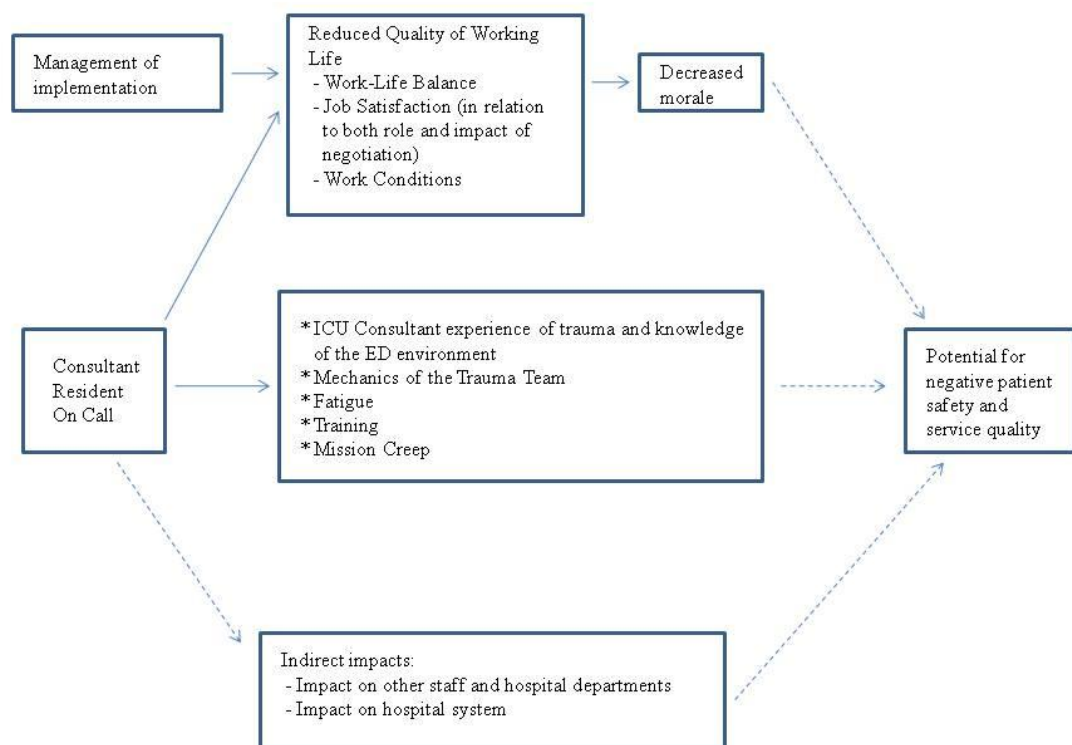


Figure 6.4: Pathways indicating how patient safety and service quality is perceived to have been negatively affected post-launch of the MTC and the introduction of the CROC.

6.8.2.1 Direct Pathways for Reduced Patient Safety and Service Quality

ICU Consultant Experience of Trauma and Knowledge of the ED Environment

The decision to use joint specialties was perceived by the consultants to have been made by management to make the trauma rota viable and to remove the need to employ external locums. Post-launch interviews highlighted an irony in the use of ICU consultants, with concerns from all but one consultant regarding the limited experience of ICU consultants in the ED undertaking emergency procedures. ICU consultants stated this was a huge learning curve as ED procedures were not part of conventional ICU training, and the CROC was completely different to their ‘normal’

role. ED consultants registered concerns about using ICU consultants - although they had training in dealing with the critical care aspects of trauma patients, the initial stages of treatment when the patient enters the hospital was a new undertaking:

“There’s been a learning curve for people who aren’t used to doing trauma resuscitation...they’re used to dealing with people from trauma in Critical Care, but they’re not as used to the initial resuscitation phase...it’s still work in progress, I think it’s patchy” (EDC 2).

When asked if this could affect patient safety and service quality, the consultant responded that it could – resulting from lack of training and experience, however, this could improve when ICU became more familiar with the role. Although this risk was perceived, there was no clear evidence to show that one specialty was a greater risk than another: *“I think the ICU consultants would say the same as me in that having a consultant there, be it from whatever specialty, you have more of an oomph to get things done...” (EDC 1).*

As the nature and frequency of trauma was unpredictable, for some consultants the level of trauma seen had been low, which, they argued, made ‘skill maintenance’ difficult if they did not undertake trauma care on their shift (this was especially the case for ICU consultants who had limited exposure to front-end trauma before the launch of the MTC). Although consultants (especially ED consultants) reported an increase in ED activity, levels of ‘actual trauma’ not being high as predicted, and some consultants reported shifts where they were not called at all. Others reported that a significant proportion of traumas did not require the expertise of a trauma consultant.

In pre-launch interviews, a few consultants discussed de-skilling if they had time away from clinical practice. This was raised post-launch – not in terms of losing experience causing patient harm – but the notion of ‘feeling rusty’, especially if departmental protocols had been introduced or modified. At these times there was an increased reliance on others in the work environment. The representative interviewed at hospital C disagreed with this notion of de-skilling: *“If you do trauma for a week then you’re deskillling your specialty, but if you are going on holiday for a week, you won’t?” (Hospital C)*. Hospital C’s representative proposed this argument was a consequence of undertaking a role the consultants did not want to do when not having the permanent system in place to ensure performance improvement, governance and education. Instead, they argued for a mentality of running trauma imbued into the system, achieved by using permanent staff and those fully engaged in providing trauma care.

Running trauma was harder for ICU consultants as a result of a limited understanding and knowledge of the ED environment. The majority of the ICU consultants discussed working in the ED as frustrating because of the different department protocols: *“It’s quite frustrating because you’re working in someone else’s department...it’s an interesting additional challenge working down there” (ICUC 2)*. Concerns were also raised by ICU consultants regarding their limited knowledge of the ED staff working alongside them. Due to the unknown frequency of trauma shifts and the perceived limited frequency of having to undertake the CROC, integration with ED staff was a concern: *“I feel very uncomfortable down in A&E...I’m not down there often enough to really feel part of the team...I don’t feel welcome down in A&E” (ICUC 3)*. ICU consultants discussed not being recognised as a consultant in the ED, resulting in communication barriers and having to spend

time establishing who they were and how they wanted to be treated when running trauma.

These results provide an interesting irony regarding the management decision to use internal ICU staff as CROCs. The Clinical Director for ICU stated that the decision to use internal ICU consultants instead of external temporary staff was because of: “...*The advantages of doing it in-house is everyone knows (Hospital A)...*” (CD ICU). Although, it was acknowledged by the ICU Clinical Director that team integration and lack of recognition could have been an issue during the first few months of the MTC, she argued that individuals involved had since developed confidence in each other, and this was no longer a problem. Even though it may have taken ICU consultants time to ‘come up to speed’, the use of internal staff was considered preferable (by management) to external locums when considering patient safety and service quality. Management at hospital D had used external consultants from their trauma network as a pragmatic decision to cover the rota. Although it was acknowledged that in some instances the system could have been slightly slower and the consultant was unknown to the team, risks were managed by ensuring that all individuals were sufficiently trained in trauma, were willing to undertake the role, and key policies and team roles were clearly outlined; in other words clear expectations and a clear ‘deal’ were negotiated. Discussions regarding the ICU consultant’s limited familiarity of the ED echoes the concerns regarding the use of external temporary staff in healthcare. However, respondents in both hospitals C and D noted that the focus should not solely be placed on the CROC, but how the trauma team members co-operate.

Mechanics of the Trauma Team

Concerns were raised regarding the effectiveness of the trauma team – the gathering of necessary personnel was defined as ‘patchy’ and dependent on the workload of the ED at the time of the trauma. If a second trauma call occurred then the trauma team’s capability had been exceeded. The direct impact for patient safety was clear – if there was a team of reliable and appropriate composition, they would work faster, safely and more effectively. The composition of the trauma team was questioned:

“You often end up with a lot of doctors who are fairly junior and don’t work in the ED...some are keen to be there, some are reluctant...I find the mechanics of that process frustrating.” (ICUC 1)

Another issue concerned the care for the patient after the initial trauma assessment and who helped the CROC after the trauma team dispersed, as sometimes this meant: *“You often find yourself being responsible for the patient but not being given the support...having to face a sick patient when you don’t get the support you need” (ICUC 5).* Some consultants suggested the roles of the trauma team needed clarification, providing a clear demarcation from their ‘usual non-trauma role’, resulting in improved team communication and improved trauma care.

These concerns added support to the idea of a dedicated trauma team – allowing for familiarisation with each other and their roles, reducing uncertainty about attendance to trauma calls and whether there would be adequate skill support present. This was raised by the Clinical Director for ICU, who reported a lack of engagement by ED registrars and ED nurses in trauma:

“You get a minimum cohort of people rather than the maximum cohort...then everyone melts away and you end up with a consultant for MTC looking after someone who has got a fractured leg...not really what it should be about.”
(CD ICU)

The effectiveness of the trauma team may have been dependent on the personality of the CROC, how in control of the situation they were, how they communicated the trauma team roles and how well they provided feedback. Representatives at hospitals C and D also mentioned personality as a factor when developing team working relationships. Clinical skills were helpful to a certain extent – but what was necessary was having suitable leaders to orchestrate the team. For this to be effective there needed to be clear opportunities for personal development, but more importantly specifications for team roles.

Fatigue

As job plans and rotas were still under negotiation, undertaking the CROC on top of their usual rotas, led to several consultants reporting fatigue, which could affect patient safety and service quality. Although the EWTD stipulates entitlement to a period of rest before and after a night shift, a consultant reported that the rest requirement pre-CROC shift was only possible if you took it as annual leave. The tiredness reported was increased if the CROC experienced many traumas during their shift: *“It’s been quite tiring...we’re having to do this on top of our normal ED on-call as well...and that can be quite tiring especially if you don’t get any sleep when you’re on-call for trauma”* (EDC 1).

Mission Creep

Fatigue was enhanced by mission creep experienced by the CROCs. Pre-launch interviews introduced this notion that CROCs may be asked to help with non-trauma roles in the ED. The majority of consultants discussed mission creep, providing examples of being asked to undertake ED roles when not leading trauma calls. The ED consultants tended not to mind clinically, as they were competent in the roles they were to undertake, but perceived the ICU consultants may not be undertaking additional roles, yet were being paid the same amount, and felt this exchange was unfair. An ED consultant described an occasion when they were on-call for ED and the CROC simultaneously (something that was not supposed to occur), but conceded that: *“You’ve got to be a dedicated CROC because if you start getting involved in something else you then can’t concentrate on the major trauma that comes in” (EDC 1).*

ICU consultants did report undertaking non-trauma roles when on-call for trauma, both in the ED and in ICU, supervising non-trauma patients, stitching and moving patients to other departments after initial assessments were completed. An ICU consultant described having to look after patients in ED they felt inappropriately trained to look after with little support, increasing the potential risks to patient safety.

However, management took a different view regarding mission creep, especially in connection with the payment consultants received to undertake the role:

“We are paying them to work. And if they are not looking after a patient because we have not got a major trauma patient, then they should be doing some other form of SPA activity...the rota that they’ve got is a working rota. It’s not on-call” (CD ED)

This statement confirms the differing perceptions of the role, and the nature of the contract. If mission creep is occurring and taking focus away from trauma patients, this needed to be addressed. In addition, if management expected consultants to work all the time, this goes against EWTD regulations and could add to consultant fatigue. These issues highlight a discrepancy between the expectations of the role from management and the consultants.

Training

Some consultants expressed concerns about the lack of appropriate training (or lack of attendance at training courses) for trauma, potentially creating risks to patient care. A trauma training day for all consultants was arranged, but some had not yet attended it (it was unknown how many of those not interviewed had yet to attend). Some consultants argued that even with trauma courses, if there were limited traumas during the shift then it could be difficult to maintain the level of skill required for trauma care.

The management representative at hospital C described a very different approach to the provision of trauma training. All CROCs had to complete an in-house trauma leader programme before they could undertake the role, and an in-house review process provided the opportunity for development. Hospital C held the view that: *“Providing that the person is trained and enthusiastic, it really doesn’t matter what specialty that person comes from” (Hospital C)*. The representative from hospital D stated they provided a trauma team leader course, and simulation sessions where all consultants had the opportunity to ‘play’ the team leader. This not only improved patient safety and service quality, but also provided an indication from the hospital that there was commitment to the service they were providing. The training

assurance process appeared to be less robust at hospital A compared with hospitals C and D.

In summary, although there was no clinical evidence to suggest that patient safety and service quality had been negatively affected by the CROC, consultants voiced a number of concerns about factors that could influence service provision, including the limited relevant experience of the ICU consultants and their lack of familiarity with the ED and its staff. Other concerns in relation to how patient safety and service quality could be affected included fatigue resulting from mission creep and the fluid nature of the trauma team. Finally, concerns regarding the training of those undertaking the CROC were discussed. These concerns indicated that the management of the MTC, and the distinct lack of clarity of expected roles could be associated with negative patient safety and service quality. In these respects, the comparisons with MTCs at other hospitals is insightful.

6.8.2.2 Indirect Pathways for Reduced Patient Safety and Service Quality

There was evidence to suggest indirect ways in which patient safety and service quality may be compromised. Once again, there were no clinical incidents reported where this was the case, but the management of the launch had resulted in a reduction of morale amongst the consultants, that could potentially affect the patient care provided.

Management of the Consultation and Launch

The pre-launch interviews indicated considerable concern among consultants regarding the management of the rota, contract negotiations and the absence of job specifications. Twelve months later, contract negotiations were still ongoing and

consultants had little knowledge about when they would be finalised. It was perceived that management were stalling on contractual issues even though the interim locum arrangement was expensive:

“I think it’s somewhat extraordinary that (the hospital) has taken so long to finalise the contract...we’ve got this insane system at the moment with (the hospital) where they are paying for the actual consultants and they are paying us to do locums because they haven’t sorted out the contract” (ICUC 4).

Consultants were unwilling to sign the contract offered by management for a number of reasons. Firstly, management had not devised a workable or sustainable rota, with consultants still waiting to hear the full details of the rota proposals. The longer the negotiations took, the more frustrated and disengaged consultants became with the process:

“I think the reality here is it is actually trying to squeeze as much out of the workforce as you possibly can without giving them anything...they’re not making it attractive...” (EDC 4).

A further issue revolved around job specification and role clarity, with consultants unclear about what the CROC actually entailed, for example, whether they were expected to be on-call solely for trauma (as the name of the role suggests), or if management expected them to undertake other duties when there were no trauma patients. The necessity of role clarity was especially important for the ED consultants who mentioned working harder than ICU consultants as they were called more frequently to non-trauma cases. Consultants felt role clarity was necessary to reduce mission creep. This standardisation of the CROC role and associated

expectations were discussed by the Clinical Director for ED when describing why the locum period continued to be extended:

“There’s been a reluctance by us to drive the standardisation of practice for the consultant performing the major trauma lead...we need to get on paper the role of the major trauma consultant and the expectations of that role, because we need to cut out some of the variability in what they do when they’re in that role.” (CD ED)

As negotiations had been ongoing for nearly two years, the consultants knew that management needed them to undertake the role, and as a result management believed the consultants had them *“Over a barrel, we need them, therefore we can’t be getting in there telling them to do it differently” (CD ED)*. As a result, any change in contracts or additional roles that consultants had to undertake were seen to breach the consultant’s psychological contracts, especially if there was limited return or recognition for any additional roles undertaken.

The Clinical Director for ICU also provided insights into why the negotiations took such a long time. Firstly, there was uncertainty about whether any changes in the job plan required a new contract and the legal ramifications of any proposed changes. However, the second reason for the delay was:

“Ineptitude...managerial circles upon circles with various people having conversations with people who couldn’t enact things rather than the people who really had the power to enact things...dubious lines of responsibility and feedback coming back from HR...we didn’t sit down together as everyone’s doing other things” (CD ICU)

Difficulties also arose as the MTC staffing at hospital A was unique, and the process of having to design a new service, and integrating HR services into this to ensure the implementation was undertaken correctly, took longer than expected. Devising job plans caused difficulties as there were various permutations within consultant specialties and sub-specialties, and the dual specialty rota meant two separate job planning exercises were necessary.

The negotiation and launch of the CROC in hospital A can be compared with hospital D. Although hospital D used external consultants for a short period of time (from the trauma network), a Trauma Directorate was developed two years before the hospital became a MTC to develop working relationships between the specialties involved. During the locum period, clear expectations were given to the external consultants from the trauma network (predominantly used out of hours, for a short period of time) in reference to the timeframe they were needed for, their payment and their roles:

“It was very pragmatic and very clear that it is going to be a short term thing, and you’d get paid £150 an hour, you only have to go out for trauma calls...and we’d like you to turn up and not screw up when there’s a trauma call.” (Hospital D)

Other internal consultants were used briefly during the locum period whilst ED consultants were recruited, but they were willing to undertake the role, and were described as, *“The trauma link to be involved”*. In this way, the use of internal staff differed from those at hospital A who were drafted in to make a rota viable, some were unwilling to undertake the role, and may not have been involved in trauma care had it not been for the way the launch of the MTC was managed.

As hospital D aimed to use solely ED staff as CROCs, new consultants hired to the department had an understanding that the 24/7 shifts were to feature in their role:

“Every new consultant has been appointed with the ‘and this is how it works and you’re going to be on full shifts and you are the trauma team leader’, this has partly made it easier because we’re not having to deal with historic contracts” (Hospital D)

Hospital D provided clear expectations, leading to the development of new psychological contracts between consultants and management. In comparison, hospital A attempted to change contracts of current consultants without the provision of clear job specifications, resulting in a perceived breach of the psychological contract:

“So it’s different to (hospital A) where some were pushed into staffing a rota to tick the Major Trauma box, whereas there’s an expectation if you come to (hospital D) as an ED consultant, that’s (trauma shift work) what you do...we are growing the team coming in with the expectation of doing nights rather than trying to convert people who are on certain contracts where they don’t have to do nights.” (Hospital D)

At hospital D, existing ED consultants were also undertaking the CROC, so their contracts needed re-negotiating. However, the ED consultants were keen to undertake the trauma role and did not feel under pressure to become CROCs. To ensure that performance standards were addressed when roles were changed and new systems were introduced, expectations were explicitly defined. Thus changes to contracts and the potential for breaches to psychological contracts were minimised as a result of clarity in job roles, specifications and how the changes were managed.

In hospital C those undertaking trauma care, were all from the ED and, *“Have trauma in their job descriptions” (Hospital C)*. There was clarity that consultants were expected to undertake a trauma role, and contracts were not renegotiated to include this. The hospital’s representative also added that those who work there, applied as a result of specifically wanting to participate on a trauma rota. Post-Darzi changes did not have a large impact in hospital C as they had been effectively acting as a MTC for many years, whereas in comparison to hospital A: *“It’s been driven by external pressure, ‘you must do this’, whereas for us it was a desire to do things better” (Hospital C)*. At hospital C there was a culture of integrating trauma care into contracts, for developing trauma care and an expectation that those applying for roles had a personal interest in major trauma. In this way renegotiations of contracts (both employment and psychological) were minimised.

An issue delaying contract negotiations at hospital A was the facilities provided for over-night accommodation. All but one of the consultants at hospital A discussed the on-call facilities, unanimously describing the room provided as inadequate in size and location. The room was on a busy corridor in the ED, meaning consultants were constantly disturbed by noise. In some cases the poor facilities and the impact this had on consultant morale overshadowed the dissatisfaction caused by work-pattern changes. The resulting lack of sleep concerned some consultants:

“That’s our main bugbear at the moment, that they haven’t sorted out any facilities where you can rest...I think that not having decent rest facilities does impact on how productive you can be” (EDC 3).

The room was not fit-for-purpose, with no facilities for consultants to check patient records, test results, access academic journals or work quietly, creating inefficiencies

in consultant work patterns. The majority of consultants stated that having appropriate facilities was expected to be built into the contract, and nothing would be settled until the facilities were changed. Even though participating as the CROC was rewarded well financially as locums, the poor work conditions had resulted in consultants reluctant to undertake the work. The nature of exchange between management and consultants was evident:

“You have to look after their quality of working life whilst they are at work...that room is totally inadequate and I don’t think that anyone will do it...if they say ‘that’s your lot’... there will be refusal (to be the CROC). I am not sure they understand that”. (EDC 4)

The management of the MTC launch in terms of the facilities provided could negatively affect patient safety and service quality not only because consultants were at risk of fatigue, but the perceived unfair exchange resulted in reduced morale and disengagement with the scheme, and an unwillingness to participate if the facilities were not improved.

An improved room had been located by the time the ICU Clinical Director was interviewed. However, this issue highlighted the different mind-set between the consultants and management with reference to the nature of the role, and what the expectations from each side were:

“...They (the consultants) are being paid to be resident on-call. They (the consultants) would emphasise the on-call. The hospital would emphasise the payment and don’t want them to be sitting there in a very pleasant area...it will get busier and the hospital will start saying we’re paying these people quite a lot of money, we want to work that asset.” (CD ICU)

This demonstrates a transactional relationship between management and the consultants. Management at hospital A ultimately expected consultants to provide the service they were being paid to deliver (major trauma care), and would provide the necessary accommodation for this. The consultants, on the other hand, expected to be treated appropriately for disruptions to job plans, and were unwilling to settle negotiations until management acted in what they considered to be a suitable manner. The Clinical Director for ED viewed the negotiations regarding facilities as a ‘power-play’ between the consultants and management, in the knowledge that hospital A was committed to delivering a trauma service, and relied upon the consultants for the provision of trauma care. In comparison, hospitals C and D had not experienced such issues, as consultants had already been undertaking the role, or were hired with specific expectations. Hospital D’s representative mentioned that facilities had not been a problem, once again as a result of hiring people directly into the post, and not having to re-negotiate plans and contracts and providing the consultants with clear expectations about what they will receive when working as a CROC.

Consultants expressed disappointment in the level of communication from management, with the perception that management could have improved engagement with the consultants, provided appropriate and timely feedback about the nature of negotiation outcomes, acknowledged consultant concerns and provided explanations regarding why contract negotiations were delayed. As one consultant noted:

“When the representative at the table tells you that they’re not allowed to discuss the progress to date with you, that can only mean that its (negotiations) not going as we would like it to” (EDC 2).

With negotiations taking longer than expected, there was a perceived disconnect between what the management and consultants believed the CROC would entail, and that improved communication with senior clinicians could have sped up negotiations. The Clinical Director for ICU agreed negotiations should have been more upfront, but was unsure that management were entirely to blame for any miscommunication that occurred. There was no knowledge concerning how the two consultant negotiators were initially chosen and how representative the two-way communication between the two parties was: *“They fed up information and you never quite knew whether it was 100% or 50%, and they didn’t always feed down”* (CD ICU). Communication between the two parties was clearly a factor in why the negotiations took a long time, and affected the trust relationship between the consultants and management.

Job Satisfaction

The management of the MTC launch resulted in reduced job satisfaction and morale. ICU consultants in particular, explained how working as the CROC took time away from their main clinical commitment which they were more interested in and they had less time to engage in educational activities. The CROC was stressful when dealing with a case they had little experience of, or boring if there was little trauma, with others saying trauma was a peripheral interest. The reduced job satisfaction resulted in low morale for some consultants, and when discussing whether this could impact patient safety and service quality, it was stated:

“I think that patients should be looked after by happy doctors. I think that you will find it very hard to objectively point to deteriorations in patient safety, but it would be nonsensical to argue that low morale does not result in disengaged doctors” (ICUC 3).

The lack of clear management decisions and poor facilities resulted in the majority of the consultants feeling undervalued, reporting reduced satisfaction, and as a result some consultants were considering not participating in the rota. This contrasts with hospitals C and D. The representative at hospital C believed consultants should not be forced into a role as this could detract from personal development, and similarly in hospital D, trauma was clearly defined in the role and consultants knew what was expected of them and were willing to participate. When staff were willing to undertake trauma, co-ordinating trauma care and patient safety became part of the trauma culture:

“Our rota was always driven by ‘join the rota if you’re interested in doing it’, not ‘join the rota because we see this as the way of covering trauma shift in order to say we have a consultant.’” (Hospital D)

Work-Life Balance

Pre-launch interviews indicated concerns regarding the impact of the CROC on the consultants work-life balance. Post-launch, the impact remained unknown as the rota and frequency of CROC shifts had not been negotiated. Consultants were working in what they perceived to be an artificial situation, signing onto shifts when they perceived it would be best for them. Although they currently had control of how frequently they worked, they were aware they would not have this when the contract was negotiated, and so the actual work-life balance impact could only be assessed when the rota was in place. The lack of a rota also meant planning annual leave was increasingly difficult. Having to stay in the hospital overnight was disruptive in terms of family schedules and being resident was made worse by the lack of appropriate facilities. If there were numerous traumas on the CROC shift, the resultant fatigue created a lot of disruption to work-life balance:

“...You don’t get any sleep and it actually just ruins the whole of the next day as well as you can’t really do a great deal. And that is happening more and more – when you don’t get any sleep at all, or you have very little sleep”.
(EDC 1)

Poor facilities contributing to the poor quality of working life when undertaking the CROC, led to consultants developing antipathy both towards the CROC and management. With three contract negotiation deadlines passed and no resolution, there were signs that some consultants were ready to withdraw.

Impact on Other Staff and Departments

Although having a CROC meant junior doctors had an experienced member of staff present to learn from, consultants from both specialties discussed concerns regarding junior doctor training. Previously, junior doctors gained experience in running trauma cases however, this was now the role of the CROC and some consultants conceded that although this was an improvement for patient safety and service quality, it came at the expense of junior doctor experience. Additionally, the ED was a busy department, regularly reported as being over-stretched and understaffed, and it was suggested that junior staff would not have time to be involved with trauma, as they would be undertaking other aspects of ED patient care:

“It’s a huge issue and getting worse...they’re disinterested in going to trauma calls, and they are not going to them, because they are in A&E doing other stuff where they feel autonomous and valued...they go to MTC’s and they’re treated as technicians” (ICUC 3).

A further concern was the difference in how ICU and ED consultants interacted with junior doctors and ED registrars. ED consultants knew which staff to request help

from, but ICU consultants did not feel able to turn to the ED registrars as readily, creating tension in the department. Consultants were aware that although patient pathways had been developed, the way trauma calls were managed by the consultants varied: *“One of the problems is that we all do things slightly differently. So the ED senior nurses get frustrated by that a little bit” (ICUC 4).* The consultant’s personality and their enjoyment of working on-call were thought to influence the nursing staff in the ED and whether they enjoyed taking part in the trauma team. If having a CROC could influence the team around them negatively so patient safety could be compromised, then this should be recognised by management. Discussions were needed to ensure junior doctors, ED registrars and nurses were happy to be involved in trauma care provision. This raises questions about how the CROC has changed the roles of other staff and how this affected the evaluation of their ‘deal’ with hospital management.

As a result of the extended negotiation process the consultants were working on locum contracts. A majority of the consultants commented that the pay difference between the consultants (£130 per hour – out of hours) and the ED nurses (approximately £130 per shift) may have created antagonism between staff levels - an unforeseen outcome of the CROC. A consultant described an occasion when they felt a ‘definite resentment’ from the ED nurses, believing this was a result of pay issues:

“It is actually a rather destructive pressure...the consultants swanning around the place getting paid £130/hour, who are there basically to supervise people, whereas the people doing the actual work and getting their hands dirty are getting paid ten times less...it is an incredibly destructive effect on the Trauma Team” (ICUC 1).

For some, the pay rate was seen as justified as a result of the unpredictable nature of on-call work and its impact on the consultant's quality of working life. However, many recognised that locum pay rates and the resultant discrepancies could make trauma team relationships difficult, especially if there was the perception that the CROC does little whilst on duty. Additionally, other hospital departments were cutting back services, or were unable to enhance services as a result of financial restrictions, and concerns arose that the locum payments could reflect poorly upon the CROC if the situation continued.

The MTC launch also resulted in perceived negative implications for other areas in the hospital. Consultants were divided as to whether 'actual trauma' had increased. The ED had experienced an uplift in patients seen as a result of 'false positives' (patients initially suspected to be trauma cases, but did not require a CROC), leading to increased pressures for the ED. Having a CROC (especially ED CROCs who often helped the ED when not dealing with trauma) masked the problem of limited resources and understaffing in the ED. Treating trauma patients involved input from other specialties, and the consequences for their workload were discussed, especially by the ICU consultants who noticed an increase for their department:

"We're getting more people coming in who are surviving, ending up in ICU, unable to go to any other clinical area in the hospital, not actually requiring ICU support...waiting for a rehabilitation bed" (ICUC 3).

The disruptions not only add further pressure to staff working in the departments, but could affect the provision of patient care to non-trauma patients.

Impact on the Hospital System and Sustainability

The cost of maintaining the CROC at the locum rate was often questioned, and considered not to be financially sustainable. The consultants were aware of the impact this was having for the hospital: *“I think it is costing something like a million pounds a year to run the MTC...from September 2010 it started to cost (the hospital) money...we have gone into negative balance”*(ICUC 1). The consultants found it difficult to justify how management could delay negotiations whilst paying the locum rates when other areas of the hospital experienced financial restrictions, and when resources that had initially been offered to develop the MTC were being pulled back as a result of the cost-constraints.

The level of actual ‘major trauma’ was variable, and led to questions regarding whether this was the best use of a consultant’s time, with large amounts of money spent on helping a small number of patients. A few consultants argued whether a similar level of service should be made available to other patients in acute medicine who would benefit from consultant care. Consultants highlighted that for the role to be sustainable, job plans required re-working and more ED staff: *“It will also probably highlight the fact that we need more whole time equivalents – we probably actually need more people...that will still be an awful lot cheaper than £1.3 million a year”* (AC).

The cost of the CROC was questioned in relation to the uncertainty about whether the patient safety and service quality improvements recognised in the London Trauma Office report were as a result of the CROC, or other hospital system changes: *“It’s difficult, a lot of other changes have happened as well, so it’s difficult to say it’s all due to having a major trauma consultant there”* (EDC 3). The current system had been slow to evolve and changes needed to be made and ‘screws

tightened' to improve the MTC, and when establishing the current system, learning and research opportunities had been missed, as well as the opportunity to develop a trauma team who would focus on trauma care provision.

In summary, the process and management of the MTC launch resulted in a reduction in both work-life balance (for some consultants) and job satisfaction. Much of this was related to failures in negotiating a suitable rota and providing adequate on-site overnight facilities resulting in delays in contract negotiation. This had unforeseen consequences – in particular, the apparent transactional relationship developing between the consultants and management, with consultants indicating disengagement with the process, and concerns regarding the financial sustainability of the role when other areas of the hospital were under financial pressures. Although direct evidence of negative affects for patient safety were not provided, a reduction in job satisfaction could influence commitment to both the hospital and the role, having implications for patient safety and service quality.

6.9 Brief Discussion of Results

The main aim of this chapter was to present the findings from the Major Trauma Centre (MTC) study, focussing on a distinctive form of temporary employment – the Consultant Resident On-Call (CROC) for major trauma at hospital A. The MTC necessitated a new working pattern, having a consultant for trauma present in the hospital 24 hours a day, 7 days a week – requiring a change in consultant contracts. Consultants asked to participate in the CROC came from two specialties – the Emergency Department (ED) and the Intensive Care Unit (ICU), a unique way of staffing a MTC. Consultants participated as the CROC on a voluntary locum basis,

in essence becoming temporarily temporary. Consultants were interviewed pre and post MTC launch regarding their thoughts on the CROC, the change in their contracts and the 'deal' that the CROC necessitated, how the launch was managed, and any implications for patient safety and service quality. Post-launch interviews also included interviews with Clinical Directors from both specialties and representatives from hospitals C and D who launched their MTCs at the same time as hospital A.

Pre-launch, consultants thought trauma patients would receive improved patient care as a result of having consultant expertise treating the most seriously ill patients, and that the dual-specialty model could lead to improved trauma communication, improving patient pathways, and the opportunities to evaluate how patient care is delivered, as well as providing the opportunity for two-way learning. The affect on work-life balance as a result of the change in work hours was difficult to estimate, as contracts and rotas had not yet been finalised. ED consultants stated that becoming a CROC provided the opportunity for skill and personal development, although job satisfaction was associated with the level of remuneration for the changes to their contracts, and the nature of the on-call facilities.

Consultants indicated that the launch of the MTC could, if not managed correctly, reduce patient safety and service quality. Both ED and ICU consultants expressed concerns about the relevant experience of ICU consultants leading one of the most taxing elements of ED work, seemingly contradicting the main aim of the MTC in the provision of expert care. The impact on other ED staff and ED patients was also mentioned. Consultants were also worried that they may be asked to help out in non-trauma cases. The content of the contract and job specification was unknown, and consultants were concerned with management behaviour in delaying viable job

rotas, communicating information and the provision of appropriate facilities. Finally, the impact on the consultant's work-life balance and job satisfaction was also questioned as a result of the change in work hours necessitated by the CROC.

Post-launch interviews were undertaken with CROCs 8-10 months after the official launch of the MTC. The CROC's presence meant that patients received timely patient care as a result of having an experienced decision maker. Critical incidents discussed in interviews and data from the London Trauma Office suggested that having the CROC did result in improved patient outcomes. The development of cross-specialty communication and the introduction of resources to aid the MTC (including the CT scanner) were reported as being beneficial to improving patient outcomes. ED consultants in particular found the role exciting, and had gained new skills, but the majority of the consultants reported that improved job satisfaction was connected to the financial compensation they received as a result of being paid locum rates when working as a CROC. Many of the apprehensions identified pre-launch, were discussed in some way post launch, with many left unresolved.

Management's decision to use both specialties came under question post MTC launch. Although there was no clinical evidence indicating that using ICU consultants resulted in reduced patient safety and service quality, ICU consultants commented on the large learning curve, as medical procedures used for trauma treatment were not included in conventional ICU training. The ICU consultants also reported feeling isolated and uncomfortable in the ED as a result of not knowing the team and the department.

The management of the MTCs launch and the consultation process led to dissatisfaction among the consultants. The lack of contracts, job specifications and a

rota resulted in uncertainty in reference to what the CROC role entailed. Consultants were unwilling to sign new contracts until management provided some clarity of expectations, and as this was not forthcoming, consultants reported feeling disengaged with the process. The lack of appropriate facilities provided by the hospital meant that consultants were unwilling to sign any contract until the facilities were upgraded, as they expected to be treated appropriately for the disruption to their working hours. The locum rate and the protracted contract negotiations encouraged a more transactional orientation from the consultants.

Pre-launch there were concerns regarding the impact on other ED staff and non-trauma patients, some of which were still present post-launch. Consultants discussed the pay discrepancies between the CROC and the nurses and how that affected attitudes of nurses towards the consultants. ICU consultants commented on initial difficulties when working in the ED and ED consultants discussed how having a consultant working for trauma and not other ED cases increased pressure for other staff. The impact for non-trauma patients was mixed – in one sense trauma patient care models had been expanded to other care pathways, and resources introduced to help the trauma centre were used with other patients. However, the number of non-trauma cases led to increased pressures for the ED, which was already over-stretched and under-staffed.

Initial concerns regarding work-life balance and job satisfaction were not resolved post-launch. Questions remained about how the working hours would truly affect their work-life balance. Some consultants reported positive job satisfaction as the CROC provided a learning opportunity which they enjoyed, and there had been an increase in the number of trauma survivors. However, ICU staff found the role stressful and not as interesting as their main clinical commitments. For both ED and

ICU consultants, job satisfaction was influenced by the poor management of the launch of the CROC, the limited communication with management and the poor facilities associated with the CROC role.

The Clinical Directors at hospital A differed in their views of the commitment of each specialty to the MTC, however, the Clinical Director for ICU commented that there had been management ineptitude in the launch of the MTC. The Clinical Director for ED highlighted that changes in management meant that the hospital was unprepared for the launch and the level of engagement among managerial staff differed.

The launch of the MTC at hospital A can be contrasted with hospitals C and D, who launched their MTCs at the same time. Hospitals C and D staffed their MTCs solely with ED consultants interested in trauma. Hospital C already had a trauma ward, and consequently, when the MTC was officially launched few changes in contracting had to occur, and round-the-clock trauma care was already developed. Hospital D chose to staff their MTC with locums from the trauma network whilst they recruited sufficient ED consultants to maintain a viable trauma rota. However, when locums were employed, they were given clear role and length expectations. Those who were recruited into the MTC at Hospital D were informed of the 24/7 nature of the trauma shifts and their job specifications, limiting contract negotiations and securing a clear 'deal'. Representatives from hospitals C and D commented that all consultants involved in the MTC were engaged in trauma care, contrasting with the more transactional approach found at hospital A.

Since the interviews were completed, work plans and contracts had been agreed and the overnight facilities (one of the stalling blocks of the process) were improved.

The CROC became part of the consultant's work plan, and the voluntary locum period (and associated locum payment) ended on the 5th February 2012, almost two years after the MTC's official launch. Consultants were willing to undertake a third round of interviews when the contract had been negotiated, but as a result of the length of the negotiation process and the time constraints of the PhD, this was not possible.

Chapter 7: Discussion of Findings

7.1 Introduction

The aim of this thesis was to use the analytical framework of the psychological contract to explore the ‘deal’ and the employment relationship between those who hire and manage temporary staff and temporary employees. Within this, the study aimed to identify the perceptions about the management of the psychological contract from various levels of management, and the advantages and disadvantages of their use in relation to patient safety and service quality. As well as contributing to the literature on the management of the psychological contracts of temporary staff, the research also aimed to have practical implications, by developing a model of best practice to reduce the risks associated with temporary staff use.

The preceding six chapters have introduced the subject of temporary employment and temporary employment in healthcare, reviewing how its use can affect organizational outcomes and patient safety and service quality and the concept of the psychological contract as a means by which the employment relationship of temporary staff could be best managed was also discussed and provided the analytic framework for the research. How the employment relationships of temporary staff should be best managed to ensure patient safety and service quality and ways to reduce any risks associated with temporary staff use necessitated further research with the aim to develop a model of best practice. This chapter aims to integrate and discuss the findings of the two empirical studies to consider what the implications of the research are in relation to the literature on the management of temporary

employment in healthcare and the psychological contract, and what conclusions can be drawn.

7.2 Structure of the Chapter

The following sections of the chapter will consider how the findings from both studies have contributed to empirical and theoretical knowledge regarding the management of the psychological contracts of temporary employees in healthcare, to answer the original research questions and extend the literature about temporary employment in healthcare and its implications for patient safety and service quality.

- Firstly, there will be a discussion focussing on the reasons why temporary staff were used in the Emergency Department (ED), and if the reasons for temporary staff use differed from a macro, meso and micro management perspective. This section highlights a managerial conflict in healthcare, with departments ideally needing a full complement of staff to ensure adequate patient safety and service quality, yet simultaneously hospitals are attempting to control staffing costs. How these decisions affected patient safety and service quality are discussed.
- The nature and definition of temporary employment in healthcare is discussed in relation to the contracting of temporary staff.
- Whether there were any preferences for the 'type' of temporary staff used was discussed.

- The perceived risks to patient safety and service quality when using temporary staff from both studies are discussed, including the management strategies in place to reduce these risks.
- The management of the psychological contracts of temporary staff in both studies are discussed in relation to the transactional and relational distinctions referred to in the psychological contract literature.
- A model of best practice when managing temporary staff, with a view to ensuring adequate patient safety and service quality based on the findings is presented.

7.3 Brief Review of Aims of Research

The over-arching research questions were to develop a greater understanding of the main challenges and risks to patient safety and service quality in healthcare when using temporary staff and how these identified risks could be most effectively addressed. In order to answer these questions, a number of sub-questions were explored including: why temporary staff were used; what type of temporary staff were preferred; how they were recruited; if there were any protocols or policies to try and obtain them; what the risks to patient safety and service quality were when using temporary staff; whether permanent staff were affected by their use; and how any risks relating to temporary staff use could be best managed. A key aim was to develop a model of best practice. The focus throughout was on management practices since this has been largely neglected in previous literature. The underpinning analytical framework was the psychological contract and in particular

the management of the psychological contract, with the need to explore the relationship between managers and temporary employees and how the management of such relationships affects organizational outcomes. How this relationship is managed is of particular importance in healthcare, where the use of temporary staff can result in reduced patient safety and service quality.

The background and theory was presented in Chapters 2 and 3. These chapters reviewed the current literature regarding temporary employment, and then specifically temporary employment in healthcare. Previous research indicated that healthcare does not employ 'typical' temporary staff only (fixed term staff and agency staff usually focussed on in the literature), and there was evidence to suggest that temporary staff use could pose risks to patient safety and service quality. The chapters also introduced the theoretical framework of the psychological contract to analyse how the employment relationship with temporary employees is managed and maintained to ensure minimum disruptions to patient safety and service quality. The challenges of studying temporary employment as a result of the variations of temporary staff found in organizations (including healthcare) were discussed, and the chapters indicated limited literature concerning the management of the psychological contracts of temporary staff from a management perspective, and how temporary staff should be best managed to provide optimal patient care.

Chapter 4 discussed the methods used in the research. Two separate studies were undertaken, both using the case study approach and qualitative semi-structured interviews with the aim to develop an in-depth understanding of the real-life hospital environment. The qualitative methods used permitted a fuller analysis of the reasons for, and the consequences of certain management decisions. The ED was chosen as a focus for the research as a result of its challenges in staffing necessitating a high

level of temporary staff use. Additionally, as a result of the rapid responses to patient needs and the heavy reliance on team communication, how temporary staff are managed in the ED becomes a topic of great importance.

The findings of the two studies were reported in Chapters 5 and 6. The first study examined the management of ‘typical’ forms of temporary employment in two London EDs from a range of managerial perspectives, and the implications of their use for patient safety and service quality. The second study examined a specific form of temporary employment found in the ED at hospital A – the Consultant Resident On-Call (CROC) for major trauma, a position necessitated as a result of the introduction of the Major Trauma Centre (MTC). The empirical work produced findings regarding temporary staff and risks to patient safety and service quality in the ED, even though there are difficulties in quantifying such risks, and ways in which the employment relationship can be managed to ensure patient safety and service quality.

7.4 Reasons for Temporary Staff Use

The purpose of this section is to answer the research questions: why temporary staff are used in healthcare, and whether different needs for temporary staff resulted in different recruitment methods. Chapters 2 and 3 presented a range of explanations for the use of temporary employment in organizations. The chapters also noted the perceived risks associated with their use for patient safety and the disruption to service quality, as well as (particularly in healthcare) the financial costs of using temporary staff, especially agency staff (Audit Commission, 2010; Hurst and Smith 2011). If these are potential outcomes when using temporary staff, the question

remained why temporary staff are used in healthcare in general and in the ED in particular.

It was proposed that organizations (including healthcare) used temporary staff when reacting to various organizational pressures, with temporary employment practices providing numerical flexibility in staff numbers allowing for variations according to organizational needs (Reilly, 1998; Connelly and Gallagher, 2006; Forde and Slater, 2006). Participants in study 1 (especially at the meso and micro level) discussed the need to fill vacant shifts as a result of short-term absences (e.g. annual leave, illness, training), and longer-term absences (e.g. as maternity leave and staff vacancies), factors previously reported by Manias et al., (2003). There was also evidence that the ED needed to be staffed on a continuous basis, ensuring adequate staff to patient ratios to deliver safe patient care (Purcell et al., 2004; Hass et al., 2006). When patient demand outweighed staff levels, and the EDs were at risk of failing to meet Government targets, clinical managers recognised the need to employ temporary staff. This need for timely care was thought to be ED specific. Thus, the respondents provided a distinction between supply side shortages and demand-side requirements of the ED.

The different managerial levels in study 1 highlighted the range of managerial concerns and priorities determining the EDs use of temporary staff. Participants at the macro level (the Associate Director for Workforce and the HR Manager) frequently discussed the use of temporary employees as a method of controlling fixed labour costs. Both hospitals A and B had a desired level for vacancies, and temporary staff were used as a buffer to enable adequate staff coverage, yet still provide the hospital with the flexibility to control the labour costs. Financial flexibility had been discussed as a reason for temporary staff use, with temporary

staff allowing for flexibility in wages to rise and fall with economic conditions (Reilly, 1998) and that temporary staff allow for the controlling of overhead costs without compromising the productivity of the firm (Wheeler and Buckley, 2000). Although temporary workers were thought of as a method to reduce recruitment costs (Parker et al, 2002), in the ED this was not always the case, as when agency staff had to be used, the costs per hour were higher than permanent staff.

In comparison, staff at the meso level (the clinical managers in the ED) at hospitals A and B were very much focussed on the use of temporary staff to provide the necessary complement of staff to ensure safe patient care and appropriate service delivery and quality. Research had indicated that shortages in medical staff can pose a threat to a patient's experience of care and the quality of care provided (Newman et al., 2001; Aiken et al., 2002). Clinical managers were aware of patient care targets and satisfaction levels that had to be reached, and often discussed the 'need' for temporary staff to ensure that staff absences were filled to maintain the expected level of service provision. In some cases, in both hospitals A and B this was in conflict with the attempt to control costs, as when performance targets were not being met, temporary agency staff were often relied upon to fill shifts at short notice. This need to fill shifts, and meet peaks in demand voiced by the clinical managers supported the research by Isaksson et al., (2010), who reported that management representatives in the PSYCONES study reported that filling absences and meeting organizational demands were the main reasons for using temporary staff.

Staff at the micro level (permanent staff who worked alongside the temporary staff) also discussed the need to fill absences and vacancies, so that patients could be treated appropriately, and in many cases permanent staff spoke of a preference for temporary staff in comparison to no staff at all. Even if the temporary staff did not

have the adequate competencies to work in the ED, permanent staff stated that the temporary staff could still be useful for undertaking basic tasks to help permanent staff.

Some of the reasons provided by macro and meso level managers for the use of temporary staff raise questions about the management of staffing in the NHS. For example, hospital B discussed the use of temporary staff as a result of having to change poorly designed rotas for middle-grade staff which had led to poor satisfaction scores in staff surveys. Managers were placed in a staffing dilemma as job dissatisfaction and burnout (as a result of the shift pattern) can lead to higher levels of stress and job resignations (increasing the number of staff vacancies) (Sherward et al., 2005; Jalonen et al., 2006; Rafferty et al., 2007), yet the use of temporary staff to cover gaps in amended staff rotas could lead to increased costs and perceived risks to patient safety and service quality. In an attempt to retain permanent staff and improve staff satisfaction scores, the rota was amended, necessitating the increased use of temporary staff.

HRM practices were also cited and specifically the protracted length of time to undertake staff checks when staff had been appointed to vacant positions, leading to the use of temporary staff in the interim. Macro level staff at both hospitals discussed problems in recruiting staff to vacant positions, which is linked to a wider systems problem surrounding the recruitment and retention of staff within the NHS. Staff shortages in the NHS have been reported frequently (Tailby, 2005; Massey et al., 2008), with underlying factors such as poor pay, increased intensity of work and high expectations of the clinical workforce often proposed as challenges to the management of the workforce (Finlayson et al., 2002; Michie and West, 2004). This provides a challenge to managers at both the macro and meso levels to develop

positive employment relationships with staff, in an attempt to retain them and thereby reduce the need for temporary staff to cover staff vacancies. This is a specific problem in London, with a young and often transient and mobile workforce.

Lepak and Snell (1999) developed a theoretical human resource architecture model proposing that HR employment choices should be based upon value (skills to improve an organization's efficiency) and uniqueness (the firm specificity of the skills that the individual can offer). The model implies that internal development would be most preferred when value and uniqueness are both high with firm specific skills and staff that are core to an organization, with investment in staff being key to the employment relationship. Using this model, temporary employees would be used when uniqueness and value are both low and the skills needed can be found easily in the external market. The use of temporary staff in hospitals A and B implies a wrong focus in HRM practices when relating to this model. In an ED, where fast decisions and a particular skill set are necessary to enable safe patient care and where protocols are department specific, the use of external temporary staff conflicts with ED's aims to ensure a high standard of patient safety and service quality. When external temporary staff are used, there is little time to develop an employment relationship with them, limiting the opportunity to develop the specific skills and knowledge necessary to work in a particular ED. This indicates a disconnect between what the model suggests should occur for optimum performance and what managers implemented in these hospitals.

Study 2 highlighted a more proactive approach to the use of temporary staff originally identified by those proposing functional flexibility (adaptability in services being offered, and changes to task demands) (Pollert, 1988; Reilly, 1998). The development of the Consultant Resident On-Call (CROC) was required as hospital A

had been designated as a Major Trauma Centre (MTC), necessitating a CROC, twenty-four hours a day, seven days a week. A new contract needed to be developed as a result of changes in the consultant's work plans demanded by the MTC, and during this process, the consultants signed up as locums to CROC shifts. However, the prolonged use of the locum contract in hospital A occurred as a result of the mismanagement of the launch and change negotiations. Due to restrictions in ED funding and the inability to recruit more ED consultants, hospital A was unable to staff the MTC solely using ED consultants. This was one of the main factors leading to the development of the joint specialty model, using ICU consultants to help staff the MTC. The joint-specialty model exacerbated complications in contract negotiations, alongside delays in developing job specifications and an agreed rota. A year after the MTC launch, the CROC's temporary locum status was still in place. Management's failure to provide what the CROCs perceived to be adequate overnight facilities meant that the consultants refused to sign a contract until improvements had been made, and the rotas, job specifications and contracts had been agreed, extending the temporary locum arrangement.

The mismanagement of the launch process in hospital A was in distinct contrast to hospitals C and D who launched their MTCs at the same time. Management at hospital C kept trauma consultants within the ED, with all consultants involved willing to undertake the role, and with minimal changes to consultant contracts, as the hospital had been functioning unofficially as a trauma hospital for some time. Management at hospital D also opted to use only ED staff for the CROC. Since the ED did not initially have the full complement of consultants, management decided to use temporary staff from the trauma network for a short period of time (until ED consultants had been recruited) with specific job roles. The new contracts had the

twenty-four hour nature of the role explicitly stated, so that consultants knew what was expected of them.

The management of the MTC launch can be used as an illustration of the conflicting management priorities between the need for specific staff and the desire to control or reduce staff costs. Management at hospital A opted for the use of internal staff as a result of the high value and uniqueness of the CROC role and because of restrictions in the funding for extra ED consultants. A temporary locum arrangement (including locum payments) in hospital A was introduced to ensure there were CROCs in place for the launch. The mismanagement of the MTC meant that the extended locum period was unnecessarily expensive for the hospital when providing the designated CROCs.

The results of study 1 highlighted a management dichotomy in the ED between those at the macro and those at the meso and micro levels when discussing why temporary staff are used. Macro level staff focussed on cost saving initiatives, whereas meso and micro level staff highlighted the importance of safe and timely patient care. The differences in management priorities meant that the implementation of cost saving initiatives were often superseded by professional priorities. Study 2 highlighted that although all three hospitals were undertaking changes to implement the MTCs and the CROCs, the different priorities in the hospitals meant that different uses of temporary staff were seen. Hospital C had little need for temporary staff as limited changes to work contracts had to be made, whereas hospital D used short-term temporary staff as an interim stage whilst additional ED consultants were recruited. In comparison, hospital A used long-term temporary staff, originally as a cost-saving measure to limit the need for further ED consultant recruitment. However, the managerial decisions led to associated costs (both economic and in terms of costs to

goodwill and the commitment of staff). Although in both studies macro management opted for temporary contracts to minimise staffing costs, the difference between managerial and professional priorities (the need for staff for safe and timely patient care) meant that the implementation of cost saving initiatives at hospital A were unsuccessful.

7.5 The Nature of Temporary Staff

Chapters 2 and 3 presented two of the challenges in the research on temporary employment – the definition and heterogeneity of temporary staff. This section indicates the various types of temporary staff identified in the ED were often blurred, leading to some challenges in identifying whether different temporary staff were of increased risk to patient safety and service quality.

The definition of temporary employment used throughout the thesis was ‘dependent employment of limited duration’, indicating the transitory nature of temporary employment and its limited duration. However, the definition failed to take into account the heterogeneity of temporary staff. Matusik and Hill (1998) and McLean Parks et al., (1998) argued that the heterogeneity of temporary employment meant that perceptions of temporary staff should not be transferred from one form to another. Results from both study 1 and 2 highlighted the range of temporary staff used in the ED: bank staff (including those who are permanent in the ED and take on extra shifts through the bank, those in the hospital but may work in the ED for extra shifts through the bank, bank-only staff), agency staff, and in study 2 in particular, locums and on-call employment. In healthcare a specific form of temporary staff is identified; permanent staff who become temporary for a specific shift, a type of

temporary employment not often discussed in temporary employment literature, but common in healthcare. It is important that these distinctions in temporary staff are made, as there is anecdotal evidence to suggest that different forms of temporary staff may develop different employment relationships with managers (Creegan et al., 2003; Page, 2008), influencing performance.

The various types of temporary staff used in the ED leads to questions about the nature of temporary staff, and whether the typical associations and management practices associated with temporary staff in other industries can be applied to healthcare, especially important as healthcare temporary staff were considered to play more of a significant and central role in service delivery in comparison to temporary employees in most other sectors (FitzGerald et al., 2007) and because of the stressful and complicated work situations where they have to perform (Batch et al., 2009).

Participants in study 1, although they spoke of the range of temporary staff used in the ED, often used the umbrella term of ‘temporary staff’ when responding to questions about the behaviour of temporary staff and patient outcomes – even when prompted and reminded about the various distinctions. The clearest distinction between the forms of temporary staff used came when discussing bank and agency staff – but within group distinctions (for example between permanent staff undertaking extra shifts and bank only staff) were rarely made. Although both hospitals reported that the majority of bank-staff were permanent employees undertaking extra shifts when they wanted to, it was unclear whether the staff came from the ED or elsewhere in the hospital (or full-time in another hospital wanting to undertake temporary employment elsewhere), and it was acknowledged that bank-only staff were used to cover shifts. Agency staff however, were typically referred

to as being ‘ad-hoc’, and in terms of policies and preferences were viewed as the ‘last-resort’. However, Clinical Managers and permanent staff still reported attempting to try and recruit the same agency staff when they were needed. The term ‘temporary staff’, as traditionally perceived, then becomes somewhat blurred, especially if the temporary employee already works at the hospital. This was emphasised in study 2, where the locums were in fact consultants from the ED and ICU who worked in the hospital full-time, but undertaking the CROC on a voluntary locum basis. Furthermore, in study 2, ICU consultants were not only signing up voluntarily for CROC shifts, but also considered themselves as temporary when working in the ED.

Further difficulties in the use of the word ‘temporary’ arose as a result of the nature of the ED environment that was the focus of both studies. The ED was described as a busy department, with a variety of patients and patient needs, often requiring the knowledge of a number of specialties. Managers at the meso level discussed individuals from other departments coming into the ED to help with patients as akin to temporary, coming to help with a specific task, who may be unfamiliar with the doctors and nurses they were working alongside. Similarly, in study 2, although the core roles of the trauma team were filled, the individuals undertaking the roles may have differed each time – in this way the idea of temporary or transient teams developed, leading to problems with communication and team stability – a factor that was mentioned in relation to temporary staff and risks to patient safety and service quality. In conclusion, temporary staff in healthcare are distinctive because of their heterogeneity, and therefore there are limits to the comparisons that can be made with the dominant form of temporary staff literature.

7.6 Preferences for Specific Temporary Staff

A further research question explored whether there was a preferred type of temporary staff in healthcare, and if there was, what management processes were in place to ensure they were secured. In both studies, the reasons for using temporary staff in the ED influenced the specific types of temporary staff preferred by managers at various levels. In study 1, macro level staff were keen for the ED to use bank staff, mainly because they cost less than external agency staff. Managers at the meso and micro level also preferred bank staff, because at both hospital A and B, bank staff were predominantly permanent staff in the department or at the hospital, who signed up with the staff bank to undertake the occasional extra shift. Bank staff were presumed to be safer for patient care and provide fewer disruptions to service delivery as they were familiar with the environment, the ED staff and the hospital's systems. Both hospitals had policies and practices in place to encourage permanent staff who wished to undertake temporary shifts to register with the staff banks, increasing the likelihood of permanent hospital staff being recruited to cover shifts and reducing the costs associated with agency staff. Managers attempted to incentivise permanent staff who wanted to undertake temporary shifts to join the staff bank instead of external agencies, as bank staff were cheaper to recruit than agency staff. Both hospitals had a policy to approach staff banks first when shifts needed filling. The House of Commons Committee of Public Accounts (2007) published costs per hour for employing a Grade D nurse through various contracts, finding that on a permanent contract they received £14.84, a staff bank nurse received £13.73, a National Health Service Professional's nurse received £13.51 and an agency nurse received £19.11 (or £16 if hired through an agreed agency framework). Costs for temporary staff at the two hospitals in this study were

unavailable, however the figures published in the House of Commons Committee of Public Accounts (2007) report clearly highlight the increased agency costs in comparison to the other contract types, and rates in London are above the national average.

Managers at the meso level, responsible for ensuring staff coverage at department level, reported it was not always possible to hire bank staff. Hospital A procured the services of National Health Services Professionals (NHSP) for recruiting temporary staff, with NHSP's aim of providing better value for money by establishing national prices for different grades of staff (predominantly nurses and administrative and clerical staff) (Hoque et al., 2008). However, as NHSP at hospital A did not provide temporary staff at doctor and consultant level, agency locums were used when gaps occurred at these levels. They were expensive and perceived by meso and micro level participants to be a greater risk to patient safety and service quality. At hospital B, the staff bank was internally managed and based in the HR department. However, problems with the staff bank were evident when the bank was closed overnight, at weekends and bank holidays, and unexpected vacancies arose. At these times, Clinical Managers had to use agency staff so the department had the necessary complement of staff to ensure service delivery, once again increasing staff costs and potentially reducing patient safety. Thus, all levels of management had the same rank order of preference for specific temporary staff, albeit for different reasons. The 'problem' or greater risk of temporary staff in terms of the perceived risks to patient safety was (mainly) an agency issue. The managerial policies at both hospitals were established to ensure both efficient use of finances and patient safety and service quality, however, the implementation of the policies was limited as a result of the way the staff banks were managed.

In study 2, CROCs were established to provide around the clock specialist expertise, accomplished at treating trauma patients, as mandated by Healthcare for London (Healthcare for London, 2009). Therefore, management decided to use internal consultants. The consultants at hospital A perceived the distinctive joint-specialty model was used because it was cheaper than recruiting the required number of extra ED consultants to make a viable rota, and that using internal consultants (whatever the specialty) would be more beneficial to patient safety than recruiting external temporary consultants. However the managers interviewed stated that reasons for the original managerial decisions were unclear and the senior manager responsible for the initial decision had moved on. The long-term use of the locum contract was necessitated by mismanagement of the launch of the MTC and in particular with a failure to negotiate consultant contracts, which proved to be a great expense to the hospital.

In study 1, managers at all levels had a preference for bank staff (senior managers for cost-based decisions and departmental managers for patient safety reasons), and although there were processes in place to secure preferred temporary staff, as a result of mismanagement in the implementation of these policies, alternative (and usually ad-hoc agency staff) were recruited, increasing costs and potential risks to patient care. In study 2, to minimise costs when introducing the MTC, the decision was made to use ICU staff so there were adequate staff numbers to make the CROC sustainable. However, senior management's failure to negotiate new contracts, including the failure to manage basic issues such as preparing job specifications for the CROCs led to the extended locum period. Consequently, initial cost minimization strategies in both studies had unintended consequences for the recruitment of staff, for costs and potential risks for patient safety and service quality

as a result of senior management's poor implementation and management of recruitment strategies.

7.7 Perceived Risks to Patient Safety and Service Quality when using Temporary Staff

The literature discussing the use of temporary staff and their implications for organizational outcomes (Chapter 2) indicated that there were inconsistencies in research findings in relation to the productivity and organizational commitment of temporary staff (De Cuyper et al., 2008). In healthcare (Chapter 3), it was reported that temporary staff could be a risk to patient safety and service quality as a result of a variety of factors (Audit Commission, 2001; The Department of Health, 2002). The following section answers the research question which asked what the risks to patient safety and service quality when using temporary staff are and how these risks could be managed. The section also provides a discussion regarding the influence of temporary staff on those they work alongside and any policies and risk management strategies in place to reduce any of their effects.

In study 1, many of the perceived risks to patient safety and service quality when using temporary staff reported by the participants echoed those mentioned in the literature. The role of environment familiarity was often discussed, reflecting the findings of Krogstad et al., (2002) and the Audit Commission (2001), who reported that staff will not be able to implement their knowledge successfully and maximise their potential if they do not know where to go, the layout of the department and where relevant equipment is kept. Kalleberg (2000) also reported that productivity

may reduce while temporary staff learn about the organization and its particular processes.

Familiarity with the team, and ensuring team stability was also discussed. Lundstrom et al., (2002), FitzGerald and Bonner (2007) and Finn and Waring (2006) all argued that knowledge sharing was key to an organization's success, and team work and team support were all necessary to maintain patient safety and service quality. Participants, especially at the meso and micro levels discussed problems with integrating unfamiliar temporary staff, and the barriers this caused with communication between temporary and permanent staff, which Hughes (1989) had described as essential to understanding how tasks are conducted. One aspect that had not been discussed in previous literature was the difficulty of communication with temporary staff from different cultural backgrounds and the resulting problems if the temporary employees were unable to communicate what help they needed, and if permanent staff had difficulty communicating what tasks the temporary staff had to do.

Chattopadhyay and George (2001) and Connelly and Gallagher (2006) commented that the lack of trust between temporary and permanent staff could have serious implications for performance outcomes that managers should be aware of. Micro level participants often discussed the ability to trust temporary staff to achieve team goals. However, this depended on the 'type' of temporary staff used and the frequency of their shifts. Problems relating to trust and communication with temporary staff can create barriers to informational and social knowledge transfer that could have implications for patient care (Lundstrom et al., 2002; Adams and Bond, 2003a).

The Department of Health (2006a) reported that the lack of training for temporary staff could have negative implications for patient safety and service quality. The staff banks at hospitals A and B reported that temporary staff who were ‘bank-only’ had limited opportunities for training (in comparison to permanent staff including permanent staff who undertake the occasional temporary shift, who had all their training needs attended to by the hospitals), as training had to be completed in the temporary staff’s own time. De Ruyter (2007), Audit Scotland (2010) and Connelly and Gallagher (2006) stated that training opportunities were further reduced if agency staff were used, as few agencies provided the necessary training, consequently leading to difficulties in maintaining the required skills for the roles. There was an assumption that temporary agencies conducted the necessary safety checks to see if temporary staff had the required skills and up-to-date training. However, participants responded that on some occasions further department-specific training was needed, potentially affecting the service provision of permanent staff if they had to provide on-the-job training to the temporary staff, thereby taking time away from patient treatment. The risk to patient safety and service quality arises from the inability of temporary staff to learn from their mistakes (Benn et al., 2009), yet temporary staff are still given front-line staffing responsibilities (Moss and Paice, 2011).

Professional development was also discussed by participants at the meso level, indicating that providing feedback to temporary staff (predominantly to bank-only or agency staff) was almost impossible as a result of the number of temporary staff used, and the busy nature of the department meaning there were limited opportunities to provide feedback. Informal feedback was provided, in that, if temporary staff worked well they were more likely to be re-hired, but patient safety

and service quality is clearly an issue when incidents do occur using ad-hoc staff, with the limited opportunities to provide professional development. Although appraisals are a method through which patient care could be improved by providing staff with knowledge of what they need to improve (West et al., 2002), translating this into practice as an appropriate intervention for temporary staff in healthcare was not always possible (Buchan, 2004).

In study 2, even though internal staff were used on a locum basis (in an attempt to minimise patient safety risks as a result of using unknown locums), potential risks to patient safety and service quality were still identified. The joint specialty model in hospital A was considered to be a source of potential risk, not only because ICU consultants were perceived by some not to have the necessary skills and experience to undertake trauma care, but also because they were unfamiliar with both the ED environment and staff, echoing concerns regarding environmental familiarity associated with temporary agency staff.

However, many of the potential risks to patient safety and service quality identified in study 2 did not result from the temporary locum contract per se, but from how management dealt with the launch of the MTC. The uncertainty caused by management throughout the length of the temporary period and the way in which the role was enacted, alongside the perceived poor communication from management concerning the progress of the MTC launch, resulted in reduced job satisfaction, and a feeling of reduced commitment resulting from the limited respect displayed by management, an effect that had previously been reported by Feldman, Doeringhaus and Turnley (1994). Although the relationship between job satisfaction and job performance is open to debate (Judge et al., 2001), in healthcare, issues such as poor working conditions, poor staff motivation and increasing the demands and intensity

of work for the clinical workforce have been reported to lead to reduced job satisfaction (Michie and West, 2004; Pearson et al., 2004; Skinner et al., 2006), with consequent staff shortages and reduced staff well-being influencing patient safety and service quality (Garman et al., 2002).

Concerns were also raised about the effects on non-consultant staff in the ED. For example, ED staff were thought to have been under increased pressure (as a result of the uplift of patients classed as ‘false positives’ and if the CROC was solely treating trauma patients, then the consultant on-call for ED would have an increased number of cases to treat). Additionally, the pay differences between the consultants and the ED staff who worked alongside them were reported to have caused resentment among staff, especially if it was perceived that the CROC had little to do on their shift. The effect on permanent staff reported by the consultants supports previous literature, for example Connelly and Gallagher (2006) described the notion of ‘distributive injustice’ where permanent staff believed they were compensated less for undertaking similar roles, or in some cases additional work, and Pearce (1993) and George (2003) reported reduced organizational trust among permanent staff. The cost of the locum CROC period was also perceived to have implications for other areas of the hospital, as resources and funds required for other developments were being withdrawn to support the CROC, creating a ‘distributive injustice’ on a wider systems level.

Although potential risks to patient safety and service quality had been identified, both hospitals did have measures in place in an attempt to reduce these risks. For example, to improve familiarity with the ED, meso and micro level staff (and macro staff to a limited extent) discussed the role and importance of induction. Foote and Folta (2002) reported that productivity of temporary staff can be inhibited if

organizations fail to provide a suitable induction, with both the Audit Commission (2001) and the Department of Health (2002) highlighting that inductions could improve the effectiveness of temporary staff by reducing their lack of departmental familiarity. Hospital A accepted that improvements to their inductions were needed, and hospital B stated that 90 percent of temporary staff received inductions, implying that risks to patient safety and service quality could still occur, especially if ad-hoc staff are among the remaining 10 percent. Other barriers to the implementation of inductions included the nature of the ED; finding somebody to undertake the induction was difficult as the ED tended to be understaffed and patient waiting times were closely monitored, and temporary staff were often brought in precisely because all the staff on duty were extremely busy. The task usually fell to permanent staff who were then unavailable to treat patients themselves, affecting service quality. In conclusion, the limited knowledge of the environment (especially in the case of ad-hoc external staff) was often thought to reduce service quality by delaying patient care, or at a more systems level analysis, delaying patient care provided by the permanent staff if they have had to undertake additional duties on behalf of the temporary staff. In study 2 there was the assumption that the ICU staff would know how the ED worked, thus staff must also recognise that those from other departments could potentially need help when entering the department.

Another initiative to improve patient safety outcomes when using temporary staff was limiting the level of medication administration that temporary staff were allowed to undertake. If patients required specific medication as part of their treatment, temporary staff would not be able to administer it, and would have to approach permanent staff for help. Not only could this delay patient treatment, but it also created added burdens for permanent staff. Thus policies developed to reduce

the occurrence of patient safety errors often led to difficulties for service quality at a wider systems level.

Both hospitals A and B had policies in place in an attempt to recruit their preferred temporary staff (bank staff, or when having to use agencies, known temporary staff from preferred temporary agencies) and to develop team familiarity and trust between temporary staff and ED staff to maximise social and informational knowledge transfer (Gruenfeld et al., 1996; Nahapiet and Ghoshal, 1998; Chattopadhyay and George, 2001). However, interviews with staff at the macro and meso level revealed that there were occasions where staff outside preferred agencies had to be used. Thus, how the policies developed at the macro level (usually in relation to controlling staff costs) were translated into practice at the meso level (by clinical managers attempting to adequately staff the department to maintain patient safety and service quality) highlights the cost saving vs. patient safety dichotomy facing the NHS. Bank staff were preferred by managers at all levels, however, if suitably qualified bank or agency staff were not available, and patient safety and service quality was at risk from understaffing, then other agency staff were recruited in an attempt to maintain patient care. The irony of this action by meso level staff is that the attempt to provide adequate patient-to-staff ratios and optimise patient care by sometimes using almost any agency staff could lead to clear risks to patient safety and service quality.

Ironically, in study 2, the decision to use the joint-specialty model for staffing the MTC at hospital A was the initiative introduced by management to ensure patient safety and service quality when launching the MTC, through reducing the need for external temporary staff. The hospital had offered training to both ICU and ED staff to ensure that all the consultants had the required level of skill; however, as reported,

not all the consultants had attended it. The MTC was launched to improve the outcomes for trauma victims (and data released by the London Trauma Office indicated that there had been improvement in trauma care). However, the management decisions throughout the MTC launch meant that job satisfaction and the quality of working life (for the majority of the consultants) was reduced.

Consequently, various risks from using temporary staff were identified in both studies, and although management actions to reduce the opportunity for such risks were discussed, in some cases the interventions had unintended negative impacts for behaviours, patient safety and particularly for service quality. However, as will be discussed, the levels of risks varied within the temporary population, and were dependent on the system that the temporary staff were placed in.

The type of temporary staff studied in research was one of the explanations provided for the inconsistent results reported when examining the organizational behaviours and commitment of temporary staff (Chambel and Castanheira, 2006; De Cuyper et al., 2008). Similarly, staff at the meso and micro level at both hospitals provided evidence of the variability of temporary staff behaviour. The results indicated that temporary staff performance may be associated with the temporary employee's motivation to undertake temporary work. De Cuyper and De Witte (2008) had distinguished between voluntary and involuntary reasons for undertaking employment. Clinical Managers and permanent staff indicated that volition could have affected the temporary employee's behaviour and commitment to the role. Examples of 'good' temporary staff were often cited as those who were seeking permanent positions, or more regular temporary work, and consequently in exchange for positive behaviours, they would hope that the department would recruit them again or offer them a permanent position if one became vacant. However, those

perceived to be working temporarily for economic incentives (Gray, 2002) were often described as less committed, as a result of their limited association with the ED and that temporary staff were being paid to cover the shift, with no further expectations. Thus, in terms of the behaviour and commitment of temporary staff it becomes difficult from these results to measure the full extent of the effects of contract type and the psychological contract, from other factors such as volition. Additionally, as temporary staff were not included in the sample, care has to be taken when discussing attitudes and behaviours of temporary staff as opinions expressed by the managers at various organizational levels may reflect individual bias or typical temporary staff stereotypes.

There was also evidence of indirect risks to patient safety and service quality. When looking at the issues from a systems perspective, the use of temporary staff was reported (especially at the meso and micro level) to affect the workload of permanent staff. Participants at the micro level reported having to undertake extra supervisory roles and operational tasks, for example, increasing patient checks if they perceived that temporary staff could not be trusted. Some provided on-the-job feedback which increased their workload and meant that permanent staff spent less time with their own allocated patient load, and limiting the time they had for writing up patient notes. This could clearly affect the service quality given to ED patients. These findings supported previous literature (Hass et al., 2006; Hoque and Kirkpatrick, 2008) who discussed inequitable divisions of tasks when permanent staff undertook roles that temporary staff were unable to complete, but extends the research with regards to the impact for patient safety and service quality. Meso-level staff at hospital B supported the work by Manias et al., (2003), when they reported having to take time out of patient care to find temporary staff to cover shifts when staff banks

could not provide necessary cover, once again reducing service quality as the more qualified staff could not undertake their roles properly. There was also evidence of how hourly pay differences between agency staff and permanent staff led to feelings of resentment from permanent staff, as had previously been discussed by Swinburn (2002) and Hoque and Kirkpatrick (2008), resulting in an unwillingness to help temporary staff, affecting the level of patient safety and service quality provided in the ED.

Reason (2000) argued that errors can occur as a result of systemic failures, including an organization's strategy, culture and approach to risk management, while Clarke (2004) and the National Patient Safety Agency (2004) emphasised that building a safety culture and an open climate was necessary for improving safety. Meso and micro level staff at hospital B discussed attempts to promote a culture of safety and supervision when temporary staff were used, attempting to gauge what level of ED experience temporary staff (especially ad-hoc temporary staff) have had previously and providing on-the-job feedback as much as they could, so any errors in patient care could be identified and learnt from. The role of communication with temporary staff was often discussed at the micro-level, in an attempt to encourage them to work with the permanent staff in achieving ED targets. However, it was recognised that at times of increased departmental pressure, this was not always possible. One interviewee cited a patient safety incident that occurred as a result of a systems failure, the incident occurring at night, with few support staff available and in a culture where the temporary staff (in this case an ad-hoc agency staff) felt unable to challenge decisions. This supports Reason's (2001) view that errors could result from decisions made at higher levels of the organization becoming apparent when triggered at the micro level. The system that the temporary employee is placed in,

and the affect that temporary staff can have on the wider system, in rare critical incidents affected patient safety, but more commonly had an influence on the service quality that staff (both temporary and permanent) were able to provide.

This section aimed to answer the research question about the nature of the risks to patient safety and service quality when using temporary staff, and how these risks can be managed to ensure improved patient safety and service quality. The results showed that temporary staff offer a potential risk due to their lack of familiarity with the ED environment, their impact on team stability, training concerns, and through their impact on the permanent staff who work alongside them. Although these risks were all identified by those interviewed, both hospitals could provide little clear evidence of temporary staff reducing patient safety. However, critical incidents and common experience indicated a greater impact on service quality, with temporary staff often reported to slow down patient care and leaving permanent staff to take on extra duties, affecting the service quality that permanent staff can provide. When critical incidents were described, the outcomes for patient care was rarely due to the temporary staff directly, but as a result of their effect on the system, and the failure of management systems to provide the relevant level of support, supervision or effective risk management (e.g. the provision of a comprehensive staff induction) and the inability to ensure that it was always possible to hire temporary staff regarded as high quality/low risk.

In comparison, in study 2 the data reported by the London Trauma Office and the incidents provided by the CROCs throughout the consultant interviews showed that the outcomes for trauma patients had improved, even when the temporary locum contract period was in place. However, risks to patient safety and service quality were still identified, including, in particular, the use of ICU consultants to provide

trauma care. Indirect risks to service quality were identified through the impact on staff motivation, as a result of management behaviour when introducing the MTC and the inability to resolve the provision of necessary facilities and a new contract.

The results from both studies show that the use of temporary staff in the ED had a greater negative effect on the service quality that patients received, as a result of the impact temporary staff have on the wider system. Poor management, in terms of delayed negotiations (study 2), and poor implementation of risk management strategies (study 1) had an effect on staff satisfaction, work-life balance and staff motivation (of both temporary and permanent staff). This not only resulted in reduced service quality for patients, but was costly for the hospitals in terms of having to use agency staff and extend the locum consultant contracts. As a result, neither the hospitals, the staff (permanent and temporary in terms of job satisfaction and motivation) and the patients benefitted from the management decisions made. This then leads to a discussion about the employment relationship and the management of the psychological contracts of temporary staff in healthcare.

7.8 The Management of the Psychological Contracts of Temporary Staff

The original research questions asked what kind of employment relationships, and more specifically, what type of psychological contracts do employers seek with temporary staff, and whether there was any evidence of differing psychological contracts with the various types of temporary staff found in healthcare. There was evidence of differences in the management of the employment relationships and psychological contracts with the various temporary staff identified in the studies.

The employment relationship has been likened to a social exchange (Schalk et al., 2010), where in exchange for benefits (wages, training) and positive organizational support, employees would display loyalty and effort towards organizational goals (Rhoades and Eisenberger, 2002; Rupp and Cropanzano, 2002), highlighting the importance of a reciprocal relationship. The psychological contract was defined as the perceptions of both parties to the employment relationship, of the reciprocal promises and obligations implied in the relationship (Guest and Conway, 2002), with any discrepancies between what is promised and delivered affecting fulfilment of the psychological contract. Researchers had argued for an increased understanding of the psychological contracts of temporary staff (McLean Parks et al., 1998), with Rousseau (1990, 1995) proposing a distinction between transactional (narrow contracts, economic in focus usually associated with temporary staff) and relational contracts (focussing on a longer-term perspective, raising expectations for future developments, usually associated with permanent contracts). Findings from studies 1 and 2 identified differences in the way that the employment relationships with the range of staff in the ED were managed.

A clear example of differences in the content of the psychological contract was evident in terms of training and professional development. Permanent staff received training and professional development and this included bank staff who were drawn from the permanent staff. However, bank-only and agency staff had to complete training in their own time. Although there was limited evidence to suggest that lack of training provision resulted in reduction in performance from temporary staff affecting patient safety and service quality, it had previously been argued that if the employee perceived they had little to gain from the employment relationship, then they adjusted their behaviour accordingly (De Gilder, 2003). This was highlighted

by the Clinical Director at hospital A, who reported that temporary staff who displayed positive employee behaviours were encouraged to apply for vacant positions, and then offered training and development when they became permanent. The Clinical Director reported subsequent improvements in motivation and commitment to their role, suggesting that the behaviour of employees is contingent upon their attitudes towards their employment relationship and how they viewed their psychological contracts.

When a permanent employee starts working in the ED, they receive a full induction, which provides the ED and the hospital with the opportunity to communicate their expectations of staff, as well as information about the hospital, its policies and practices. Those employed by the staff bank who already worked in the department or elsewhere in the hospital would have also received much of this as they are permanent employees. However, bank-only and agency temporary staff were not provided with the same level of induction (or may not have been given an induction at all) partly because it was not perceived by management to be a worthwhile investment for a single shift and partly because of time pressures in the ED. Not only could this mean that temporary staff had limited awareness of the environment, but also the time to communicate expectations is reduced. Guest and Conway (2002) argued that communication of the contract is important, and there should be effective channels of communication to ensure a shared understanding of what is expected (Rousseau, 2001). Having an appropriate induction would mean that communication at the initial point of entry would lead to fewer misunderstandings.

Results from study 1 indicated that both hospitals had a preference for temporary staff the department was familiar with, so that ED staff had the opportunity to develop a relationship with them, and felt they could be trusted and relied upon to

provide positive patient safety and service quality. This continued use and preference for temporary staff suggested an exchange relationship had developed in lines with that described by Schalk et al., (2010) and Cropanzano and Mitchell (2005) when positive obligations from both sides (opportunities for extra shifts in return for performance on shifts) were perceived, and over time the relationship becomes trusting and loyal. In comparison, agency staff (especially in hospital A), were often referred to as the 'last-resort', were perceived as less reliable and providing a lower level of patient care, and as such developing a fuller psychological contract with them was not considered as important.

Staff at the micro level reported the importance of attempting to help and integrate temporary staff, providing on-the-job feedback and encouraging temporary staff to ask questions and approach appropriate staff for help when they are unsure of policies, protocols or patient treatment, with the hope that temporary staff would respond accordingly – in essence attempting to develop a positive exchange relationship during the shift to allow for social and informational knowledge sharing, so that patient care and would not be affected by staff unfamiliarity (Gruenfeld et al., 1996). Beliefs about other's actions do develop over time (Edmondson, 1999) and although temporary staff, especially ad-hoc staff, may only be present for one shift, when attempts are made to develop an open climate and integrate temporary staff, it provides the opportunity to develop a local level relationship with them for the duration of the shift with the hope this would improve communication, performance and consequently patient safety and service quality.

Although this thesis focussed on the management of the psychological contracts of temporary staff, the results have shown that attention has to be paid to the psychological contracts of permanent staff when temporary staff are used in the ED.

Schalk et al., (2010) found that permanent employees reported that relational components of the psychological contracts could be difficult to fulfil, and the more extensive the content of the psychological contract the greater the potential for contract breach. Permanent staff in study 1 often reported having to undertake extra duties when temporary staff – particularly ad-hoc staff – were recruited in the ED (for example, having to monitor their output, check notes and diagnosis, supervise temporary staff, and on some occasions conduct the temporary staff inductions), increasing their workload. Permanent staff reported that they received no compensation of any sort for this, and that the stress of undertaking these additional activities was increased by the knowledge that some temporary staff (agency staff in particular) were paid more per hour than the permanent staff while often treating fewer patients. This is an illustration of the ‘distributive injustice’ discussed by Connelly and Gallagher (2006), and reflects a breach of their psychological contract, as their extra obligations to the ED were not reciprocated by senior management. Some staff reported that this perceived unfairness reduced morale among the permanent staff. On some occasions this perceived breach of their psychological contract was manifested behaviourally, with permanent staff expressing an unwillingness to help temporary staff (especially if temporary staff were unknown), preferring to concentrate on their own duties. This could lead to risks to patient safety and service quality if temporary staff remained unmanaged.

Study 2 provided the opportunity for a longitudinal study of the nature of temporary contracts, the role of the employment relationship and its implications for organizational outcomes. Prior to the launch of the MTC the consultants had a predominantly relational psychological contract, with both ED and ICU consultants reporting broadly positive reciprocal relationships with management. Consultants

were offered training for their new role, and as a result of changes in the contracts and work patterns locum payments were offered as a temporary arrangement until new contracts were agreed. These gestures by management could be seen as an attempt to maintain the relational contracts with the consultants during a period of change and uncertainty and this was reflected in the generous financial compensation for the overnight role. However, post-launch interviews indicated that the psychological contracts of the consultants had become more transactional as a result of the poor management of the processes. Uncertainty about when the new job specifications and rotas were going to be introduced and dissatisfaction with the overnight room provided by the hospital, had overtaken the importance of developing a new contract for the CROCs. Additionally, some consultants took on extra responsibilities when working as the CROC, unrelated to trauma, to help the busy ED. Although this could be seen as justified as a result of the locum payment, from the consultant's perspective, it could also be perceived as an over-fulfilment of their contract, when management were seemingly unwilling to maintain their side of the 'deal'. The limited communication from management reported by the consultants led to a lack of clarity about what was being offered. This mismanagement of the process resulted in perceived breaches of the relational psychological contracts at hospital A.

Herriot et al., (1997) argued that if employees perceived that the contents of their psychological contract were breached, then employees may reduce their commitment and motivation. This perceived breach in the psychological contract by management resulted in several reports of reduced satisfaction and commitment among consultants, with some consultants saying they were less motivated to sign up to become CROCs.

The perceived breaches in the psychological contract and the perceived absence of reciprocity meant that trust in management reduced, resulting in a more transactional-based relationship, with consultants unwilling to sign a new employment contract until acceptable terms had been presented. The consultants were redefining their psychological and employment contracts, to ensure that they got the 'deal' that worked for them. The 'deal' in this situation involved negotiating suitable facilities for working overnight, and a rota that would not negatively affect work-life balance, including suitable time off after the CROC shift for recuperation.

The management of the consultant employment relationships in hospital A during the launch of the MTC differed from that of hospitals C and D. As hospital C was unofficially functioning as a MTC, the employment relationship and contracts required limited redefining, and consequently a relational contract between management and consultants was maintained. At hospital D, changes in staffing and contracts did occur, but new contracts were developed for the consultants recruited for the ED to undertake the CROC, with clear communication in the initial stages of contract management, to ensure that misunderstandings about what was expected and what was to be given in return were reduced. The comparison between the launch of the MTCs in the three hospitals, confirms that the problems discussed by the consultants at hospital A were not as a result of the introduction of the CROC role per se, but because of the mismanagement of the process, which included the temporary locum contracts, resulted in a breach of the consultants' psychological contracts. Consequently, the consultants developed a more transactional employment relationship. Experiences in the other hospitals confirm that management had choices about how to manage the changes and the employment relationship. In hospital A it appeared that management failed to fully understand

the implications of their approach for consultant behaviour, costs and the impact on wider hospital systems. The lengthy process of developing the employment contract, combined with the poor management of the change process altered the psychological contract towards a more transactional relationship, which in turn extended the negotiations and made them more difficult, as well as providing an unwelcome backdrop to the introduction of the new MTC.

The results of the two studies have highlighted the variations in the management of the psychological contracts for different kinds of temporary staff. One might assume that managers would want to develop clear transactional relationships with temporary staff (especially ad-hoc temporary staff) or maintain relational contracts (in cases such as study 2, where permanent employees undergo changes to their original contracts as a consequence of organizational change). Both would reduce the opportunities for contract breach, with the aim to achieve positive organizational outcomes. However, results from the two studies indicated that when managing temporary staff this may not be management's priority, especially when cost-saving measures are implemented and when there are time pressures in a busy ED.

The predominantly transactional psychological contracts identified in study 1, highlighted managerial dilemmas when recruiting temporary staff. The employment relationships with temporary staff were transactional, but managers (especially at the meso and micro level) required a level of performance similar to permanent employees to maintain patient safety and service quality. However, because of the busy nature of the ED, when ad-hoc temporary staff were recruited, the same level of employment relationship could not be provided, with negative consequences for service quality and the quality of working life of permanent staff.

Study 2 highlighted a more complex relationship in the management of the psychological contracts of temporary staff. In hospital A, the consultants were on permanent contracts in their specialties, yet were asked to sign up as temporary locums only to undertake the role of the CROCs, and in return, they were paid a consultant locum rate. As the consultants were permanently based at the hospital, trauma training was offered to them by the hospital, some form of contract consultation was occurring (although consultants were not happy with the level and clarity of consultation), and compensation for the change in rotas was offered by management (both financial and in terms of time off after the CROC shift).

However, as time progressed, the mismanagement of the negotiation process shifted the focus from a relational to transactional relationship. Management seemed either unwilling or unable to provide a suitable rota, job specification and overnight facilities. In return, as a result of the perceived breach in expectations and to make the exchange 'fair', consultants were unwilling to sign new contracts until these issues had been rectified. The consultants perceived that management were unwilling to invest in the CROCs, and as such, felt like 'temporary staff'. The cross-site comparisons in hospitals C and D indicated managerial methods whereby the relational contract with staff could be sustained, or developed, including providing all the necessary facilities and conditions for the CROC to be sustainable, clearly communicating the terms of the new role and providing relevant compensation for contract changes, reducing the opportunities for uncertainty and contract breaches. Changes in management and an apparent lack of co-ordination across different management levels appears to have resulted in delays and a lack of urgency in resolving the new contract. The relatively new local management were beginning to

address these challenges and make some progress at the end of the data collection period.

Many of the consultants stated that they were not disappointed with their line manager about how the CROC was launched and the delays in the contracting process. In fact, they reported being able to speak freely to their manager about how the CROC was affecting their role. Although blame was not directly attributed, consultants described disappointment with the level of management above their line managers. The CROC consultants were, in effect, undertaking two separate roles, namely their established pre-CROC role and their role as CROCs. This raises the question of what happens to relationships and particularly the psychological contract in the established role if the psychological contract in their CROC role has been breached. This presents potentially challenging issues for management and also provides a further focus for future research among those filling dual roles.

The consultants in study 2, also discussed how the launch of the MTC and the CROC could affect the roles of those they worked alongside, albeit in different ways to those identified in study 1. For example, the consultants raised the issue of reduced opportunities for the training of junior doctors in trauma, as they would no longer be able to lead trauma calls. Additionally, as the ED was experiencing an uplift in patient throughput (as not all the cases initially classed as trauma were actually trauma, and therefore would not be treated by the CROC but by the ED consultants or registrars), it was reported that junior doctors were deciding not to offer to become involved in trauma cases or helping in the trauma team, as they had other departmental tasks to undertake. This could be seen to breach the psychological contracts of junior doctors who would have previously expected to

have an input in the treatment of trauma patients, and the associated major trauma training, which was no longer available to them.

In study 1, meso and micro level staff discussed ‘distributive injustice’ as permanent staff often had to undertake increased duties, both supervisory and practically. In the MTC study, consultants were increasingly aware of a financial injustice, especially in relation to what the ED nurses were earning. It had been reported that CROCs earned £130/hour (out of hours), whereas the nurses were paid £130/shift. Some of the consultants described definite resentment from the nurses at this pay discrepancy, especially when the CROC had little or no trauma on their shift. Consultants were aware that the ED had seen a rise in cases as a result of trauma ‘false positives’ resulting in increased pressures for an already busy, under-resourced and understaffed ED. This financial injustice could be seen as a breach in the psychological contracts for ED nurses working alongside the CROCs, who had no changes in their salary, and were having to undertake more roles on shift to cover the cases that were in the ED that did not come under trauma care. An interesting study for future research would be to ascertain who the permanent staff believed had breached their psychological contract – the consultants themselves, or those managing the implementation of the MTC by establishing the locum contract and the resultant locum payment.

This research aimed to determine what kind of employment relationship and more specifically, what type of psychological contract managers sought with temporary staff, and whether there was evidence of differing exchanges between the types of temporary staff in healthcare. The results have indicated, that especially with ad-hoc temporary staff, a predominantly transactional contract is developed, shown by reduced (and in some cases no) induction, differing terms and conditions in relation

to the training offered to them, and no opportunities for future development. In essence, ad-hoc temporary staff are hired and paid often on a one shift basis for filling a gap. The relationship with bank staff, especially those known to the department, differs slightly, as permanent staff discussed engaging them more fully, and providing on-the-job feedback. Study 2 highlighted how the mismanagement of relational psychological contracts, leading to perceptions of contract breach affected the behaviours of staff, resulting in a more transactional relationship between managers and staff. The cross-site comparisons provided evidence about alternative and potentially more effective ways of managing contract change to maintain both a positive psychological contract and levels of performance among key staff such as ED consultants.

7.9 Developing a Model of Best Practice

Ideally, there would be no need for temporary staff in healthcare, and departments would have shifts covered with a full complement of permanent staff. Making allowances for sickness and maternity leave (and other justified absences such as holidays and training), it could be argued that the consistent need for temporary staff could be construed as a series of management failures. In healthcare, and the ED in particular, this is especially important to consider if the resultant use of temporary staff can lead to negative patient safety and service quality and increased staff costs. As this research has indicated, temporary staff are relied upon in the ED and this seems likely to be the case for the foreseeable future in the large London hospitals. Therefore a model of best practice needs to be developed so that psychological contracts are appropriately managed to ensure positive patient safety and service

quality. Building on the findings of this research and on the relevant literature, outlined below is a model of best practice focussing on the different levels of management.

7.9.1 Macro Level

The results from both studies implied that executive level managers were concerned with staff costs and flexibility ahead of patient safety and service quality, and because of their limited interaction with clinical staff at the micro level, they had given little thought to developing exchange relationships with temporary staff. Policy development and implementation at the executive level should enable managers at other levels to have optimal opportunities to recruit their preferred temporary employees.

The role for managers at the macro level might usefully include the following:

- Maintaining patient safety and service quality as a higher policy priority than contracting costs. This should be reflected in staffing policy and practice.
- Keeping accurate and accessible data to inform policy across the data sources and managerial levels.
- Ensuring that policies and practices the hospitals have in place reflect the need for adequate staffing levels and are implemented correctly at all management levels, while simultaneously controlling staff costs. In study 1 both hospitals had policies in place prioritising the staff bank, yet both staff banks had limits in delivering the necessary service, resulting in agency use. Managers should

modify the services that the staff banks provide, by widening the remit in the type and level of staff recruited by banks (in the case of NHSP at hospital A), and by extending the opening hours and accessibility of the staff bank (hospital B). This would potentially limit agency staff use, reducing the expenditure on temporary staff and minimising risks to patient safety and service quality associated with agency staff.

- Providing further incentives to encourage permanent staff who wish to undertake occasional temporary shifts to sign up with the staff banks, either through increasing the bank rate (which would be expensive), or making it clearer that bank staff will be prioritised over external agencies when filling shifts. The challenge this raises, and could be an avenue for further research is understanding why individuals choose to use temporary agencies instead of joining a staff bank – is it solely connected to the level of pay, or are other factors involved?
- If agency staff are necessary, management must ensure that agencies within the hospitals patient safety framework are used, with agencies monitored periodically with respect to the standard of staff they provide and the required staff checks (CRB, mandatory training, full registration, etc.).
- When, as in study 2, management have to undertake contract changes to permanent staff as a result of implementing changes to work plans, the results highlighted the importance of maintaining a relational psychological contract with the staff involved. One of the main ways to achieve this is to make effective use of communication as this could result in a less frequently breached

set of promises, leading to a fairer exchange (Guest and Conway, 2002). The researchers also suggested that with improved communication, there would be a positive impact of policies on employee attitudes and behaviours. Clarity in what the new contracts will include, a fairly negotiated rota (if work-plans are being amended) and a job specification should reduce employee uncertainty, and result in a perceived 'fairer' exchange.

- Study 2 highlighted limited coordination in the planning and implementation of policies. Therefore, managers should coordinate policy across senior management and between levels of management. A coherent approach was not evident with respect to the implementation of the MTC, with the consequent problems.
- Managers should develop and communicate an agreed approach for all levels for managing the employment relationship and psychological contracts of the various types of temporary staff.

7.9.2 Meso Level

Results indicated that clinical managers had a distinct preference for temporary staff who they were familiar with, had developed a relationship with, and who they trusted to deliver safe patient care. In most cases, clinical managers had a hierarchy of choice regarding the type of temporary staff they preferred to fill vacancies.

The role for managers at the meso level might usefully include the following:

- Attempt to hire the preferred temporary staff when possible. Ideally ED staff who worked for the bank would be used, followed by bank staff who worked in

the hospital. If neither of these were available then bank-only staff were preferred to agency staff as a result of cost effectiveness. If agency staff have to be used, managers should use agencies within the hospital's agency framework, and request staff known to provide safe patient care.

- The dilemma for clinical managers is that the employment relationship with ad-hoc temporary staff is most likely to be transactional, as there is a limited time for a relational exchange to develop. The role of managers is then to develop a clear transactional relationship with the temporary staff, so expectations from both sides are agreed to avoid contract breaches.
- If unknown temporary staff have to be used (if there are no suitable bank staff available, and service delivery needs are to be met), measures should be introduced in an attempt to properly induct staff to the department ensuring optimal behaviours. For example, managers must ensure that staff inductions are conducted not only to increase environmental familiarity, but temporary staff should also be made aware of the roles expected of them, so in exchange, temporary employees can respond appropriately. Hospital B had a checklist of key features to be included in an induction, especially if time is limited, as is usually the case with ad-hoc temporary staff. Managers should therefore ensure that this is implemented. Hospital A should develop a similar checklist and use it when ad-hoc temporary staff are hired. The level of induction for temporary staff will vary depending on their level of familiarity with the ED.
- Temporary staff (if ad-hoc) should also be introduced to key members of the ED staff (by the Clinical Lead for doctors if they are locums, or the Matron if they

are nurses) so they know who they are working alongside and who they can approach if they have questions regarding patient care or departmental policies (in hospital B temporary staff were encouraged to attend the staff handover so this would occur), developing communication between staff and developing a safety climate. If temporary staff feel that they are being supervised in their role, then in return, they may respond with greater levels of organizational citizenship behaviour and commitment to their role.

- Additionally, clinical managers need to be aware of the effects of temporary staff on permanent staff. In study 1 especially, the managers were aware that permanent staff had to undertake extra duties. Managers should provide clarity regarding the level of supervision expected from permanent staff. The results indicated that the level of supervision necessary was dependent upon on the number and the familiarity of temporary staff on shift. Consequently, if managers implemented the policies for hiring temporary staff correctly, recruiting those familiar with the ED, the implications of temporary staff use for permanent staff would be reduced.

7.9.3 Micro Level

Staff at the micro level in study 1 reported having little influence in the decisions regarding temporary staff recruitment, but were often those who had to ‘manage’ temporary staff on a day-to-day basis, usually having to deal with the consequences when temporary staff under-performed, affecting service quality.

The role for staff at the micro level is:

- To induct temporary staff, and provide some on-the-job supervision. Temporary staff would then know who to approach if necessary, potentially reducing the risks of temporary staff making mistakes, or permanent staff having to double-check treatments.

- To communicate any problems with temporary staff to clinical managers, reducing the possibility of lower quality temporary staff being recruited again. However, this requires an openness of communication from all managerial levels, and successful implementation of strategies to make recruitment more effective.

7.9.4 Wider Systems

Although this thesis focussed on the management of the psychological contracts of temporary staff in the ED, it is important to look at the issue from a wider systems level.

- Participants reported that changes in the training of middle grade doctors meant that there were more gaps in the middle grade rota, resulting in temporary staff having to fill gaps. The challenge remains to see if training at a wider level can be improved to minimise the impact on hospital rotas, reducing the need for temporary staff.

- All managers reported that staff vacancies remained a distinctive problem for EDs, with difficulties in recruiting permanent employees. The discussion of these findings has resulted in a number of challenges, including making the roles

in the ED more appealing so that professionals would want to apply for them, and improving job satisfaction by ensuring fairness of treatment so that staff remain in their roles.

7.10 Summary

This chapter has shown how the findings from both studies answered the original research questions about developing a greater understanding of the main challenges and risks to patient safety and service quality when using temporary staff, and how these risks could be addressed. The chapter identified the role of the management in developing employment relationships and psychological contracts with temporary staff and the nature of the ‘deal’.

The reasons for temporary staff use highlighted the dichotomy between macro and the meso and micro levels of management. Macro level managers focussed on cost management strategies, whereas meso and micro level management prioritised the need for service delivery. All levels of management had a preference for bank staff – especially those more familiar to the ED – but for different reasons, based either on concern for cost minimization or patient safety. Consequently, how the managers ensured that the policies for recruiting the preferred staff were implemented, influenced both cost and patient safety and service quality.

Perceived risks to patient safety and service quality were identified, particularly when using ad-hoc agency staff, including the lack of familiarity with the environment and ED teams, the lack of personal development and the limited conditions for training. Both hospitals had risk management initiatives in place to reduce the opportunity for these perceived risks. However, once again, how well

they were implemented in the ED affected outcomes. What became clear was the influence of temporary staff on service quality, as a result of their impact on the wider systems, especially permanent staff, who often reported having to provide extra supervision and complete tasks that temporary staff are unable to complete, causing delays and reducing the service quality that patients received.

Although there were difficulties in defining temporary staff in healthcare due to its heterogeneity and its distinctive nature, meaning that it is not comparable with much of the temporary staff literature (predominantly fixed-term contracts), there was evidence of differences in the management of employment relationships and the psychological contracts with the different types of staffing groups found in the ED. The psychological contracts with ad-hoc agency staff and bank-only staff in particular, demonstrated that with unfamiliar temporary staff there was a transactional relationship with management, with temporary staff effectively getting paid to fill the shift. Preferred staff, and those used more frequently had a greater opportunity to develop a relationship with managers, and although from a meso-level the relationship was still predominantly transactional, permanent staff reported the importance of integration and communication in an attempt to develop a more relational exchange, which would not be possible with ad-hoc staff due to the limited time scale. Study 2 highlighted the importance for management to deliver the promises expected in a contract, as if a breach is perceived by employees, then they in return may reduce their commitment, motivation and morale towards the organization and the role, resulting in a re-evaluation of the 'deal'.

A model of best practice was developed in relation to macro, meso and micro levels of management, highlighting the importance of implementing appropriately integrated policies relating to the recruitment of preferred temporary staff,

developing and maintaining clear psychological contracts, reducing the opportunities for perceived contract breach, and being aware of the psychological contracts of permanent staff who are affected by the use of (ad-hoc) temporary staff.

Chapter 8: Conclusions

8.1 Introduction

Temporary employment in healthcare is prevalent yet necessary and costly (both in terms of financial costs and the risks to patient safety and service quality). This thesis has aimed to use the framework of the psychological contract to explore the previously neglected management perspective on the employment relationship with temporary staff in Emergency Departments (ED). The research was challenging in some places, yet has still contributed towards understanding and managing the risks associated with using temporary staff in EDs and to the management of their psychological contracts.

This chapter identifies some of the challenges and limitations of the research, as well as suggesting how the research can be extended.

8.2 Contributions of the Research

This study explored the risks of using temporary staff and the management of the psychological contracts of temporary staff in EDs and the implications for patient safety and service quality. A review of the literature indicated that temporary staff are needed to ensure adequate staffing levels, yet simultaneously could lead to risks to patient safety and service quality. The psychological contract was used as a way of studying the employment relationship between managers and temporary staff, to see if how the psychological contract was managed influenced patient safety and service quality. Despite the difficulties encountered throughout the research, the work has made several contributions towards our understanding of temporary

employment in EDs and the management of the psychological contracts of temporary ED staff.

The research highlighted the distinctive characteristics of temporary staffing in healthcare. The review of the literature had previously indicated that in other industries various forms of temporary staff had been identified, this research uncovered the complex nature of temporary staff in the ED. Within the bank and agency distinction, there were also permanent staff who undertook temporary shifts when necessary. The description of temporary teams in the ED as a result of the various specialties that may be required to treat patients also blurs the 'temporary' definition. This research identified a hierarchy of preferences when recruiting temporary staff in the ED, the increased need to specify the type of temporary staff being researched due to the heterogeneous nature of temporary staff (both within and between types), and to acknowledge the fluidity of staffing patterns in healthcare and the specified nature of hospital departments, meaning that 'temporary' staff could even include staff when they must enter a different specialty.

The studies also revealed the competing priorities between different levels of healthcare management, and how some of the resulting decisions could affect patient safety and service quality. Macro level management focussed primarily on costs, and viewed temporary staff as a cost-efficient way of buffering staff numbers if and when necessary. However, meso and micro level management clearly identified that maximum patient safety and service quality was required, and consequently temporary staff were utilised to ensure a full complement of staff to provide the service. Although, in theory this meant that all three levels of management preferred the use of known bank staff, the failure to implement policies and practices, and the nature of the ED often meant that agency staff had to be used, resulting in increased

staff costs and greater perceived risks to patient safety and identified risks to service quality.

The focus on the management of the psychological contracts of temporary staff addressed this previously neglected perspective. The findings reported that the psychological contracts of temporary staff in the ED were predominantly transactional, with temporary staff essentially being paid to fill the gap. However, staff at the micro level attempted to develop a more relational contract with temporary staff, especially those hired more frequently with the hope this would improve patient outcomes. These results suggested that it would be preferable for meso level managers to develop a clear transactional contract (as there is limited time to develop a relational contract) with temporary staff, reducing the opportunities for contract breach, and if it is possible, micro-managers should attempt to induct staff appropriately, so temporary staff can perform optimally, and feel able to communicate to those they are working alongside. In addition, the research highlighted an absence of any systematic attempt to manage the psychological contract among management in general and no consensus on the content of the psychological contracts across different management levels.

8.3 Limitations to the Research

There were a number of limitations to the present research, including methodological, practical and conceptual issues. These are considered in more detail below.

8.3.1 Conceptual Limitations

Difficulties in defining what constitutes temporary staff in healthcare in general and in EDs in particular were identified, with participants in both studies discussing the issue of temporary teams, the differences between bank and agency staff, and although not a focus of this thesis, some participants also mentioned junior doctors on rotation, who display some of the characteristics associated with temporary staff during their fixed term in a department, questioning where the line for ‘temporary employment’ should be drawn. This thesis illustrated a wide range of temporary staff, from the more conventional (agency staff) to the very distinctive (CROCS), and so it must then be questioned whether the OECD definition of temporary staff “dependent employment of limited duration” (De Cuyper et al., 2010) is appropriate in healthcare, or whether modifications need to be made due to the distinctive nature of temporary staff in the NHS, in particular for permanent staff who become temporary for specific shifts. In many cases during the interviews, the umbrella term of ‘temporary staff’ was used by the participants, making the distinctions between the various forms of temporary staff identified difficult. In healthcare, it became evident that clearer distinctions between the forms of temporary staff are needed, especially when this can affect patient safety and service quality. This research has therefore highlighted the importance of broadening the concept of temporary employment.

Another conceptual issue raised by this research is the applicability of the psychological contract to temporary staff who work only one shift. Recent research using the framework of the psychological contract in relation to temporary staff (e.g. PSYCONES) used temporary staff on fixed-term contracts, with the average tenure

of one and a half years. However, in healthcare, one-shift temporary staff are common, limiting the opportunity to develop a psychological contract.

8.3.2 Methodological Limitations

Research Design

The case study approach was chosen because of the nature of the research problem, the aims of the research questions, and the need to study complex, real-life research environments. The qualitative approach allowed for an in-depth consideration of the nature of the management of temporary staff in and between the hospitals that provided the focus of the research. The case study has been criticised for its lack of generalizability to other populations and research studies (Yin, 2003). However, in case studies the role of theory is important, and becomes a method for generalizing case study results (Yin, 2003b). This study has explored the findings of the management of temporary staff in healthcare in relation to employment relationships, social and economical exchange and the psychological contract. The use of theory can then be used to compare the empirical results across other healthcare contexts, providing an analytic generalization (Yin, 2003).

To meet the aims of this research, a qualitative approach was adopted to collect in-depth information on policies and practices and to gain different stakeholder perspectives. Semi-structured interviews were chosen as a result of the flexibility of the method and the opportunity for probing. Ideally, a case study of this type would include information on background data, such as staffing levels in the ED, the level of vacant shifts and data regarding the hours and costs of temporary staff. This would have been helpful to contextualise the problem (how often they are used, the

times of day they are predominantly used, the proportion of bank and agency staff used), providing a clearer understanding of the nature of the problem. Attempts were made to access this data, but the data provided in relation to the hours of temporary staff use was full of errors and gaps, meaning that it could not be used. When further clarification of the data was asked for, the researcher was informed that gaining access to information about the hospital's spend on temporary staff would be more useful as the way that working hours were reported was unreliable. However, due to the sensitive nature of the topic amidst the climate of cost saving, access to information relating to the financial costs of using temporary staff was not permitted.

Quantitative measures of incident rates would add further depth to the understanding of the nature and frequency of incidents in the ED. However, Waring (2005) reported queries regarding the accuracy of incident rate reporting (both in terms of whether the incident was reported at all and the accuracy of the information that is reported). This adds further difficulties in trying to determine whether the use of temporary staff does lead to increased negative patient safety and service quality outcomes. Critical incidents provided useful examples of specific events but these cannot indicate the frequency of the events they illustrate. Other forms of data collection were considered, including observations, however, the nature of the busy EDs meant that this was not a practical method of data collection.

Research Sample

This study used large EDs in London as case hospitals which were probably extreme examples of the challenges of using temporary staff. Consequently, the results may not be generalizable to all EDs.

Although the research focussed on the management of the psychological contracts of temporary staff, attempts were made to interview temporary staff, to gain their perspective on the management of their contracts, employment relationships and patient safety and service quality matters. However, due to data protection issues from both hospitals, the staff banks and agencies, contact with temporary staff had to go through gate keepers, even though the study had ethical clearance. A description of the study and researcher contact details were given to the gate keepers in an attempt to recruit temporary staff, however this proved unsuccessful, and consequently, temporary staff were not included in the study.

Additionally, the participants in the study may not have been fully representative of ED staff. In study 1, the permanent staff interviewed in hospital A were predominantly middle-grade doctors, whereas those interviewed in hospital B were predominantly nurses (ranging from a level 5 nurse to a senior nurse manager). Although these participants fit the sample description of permanent staff who work alongside temporary staff, doctors and nurses may have different views about how temporary staff are used and how they should be managed. Similarly, there were differences in the staff interviewed at the meso-level (nursing managers were not interviewed at hospital A, and administrative managers were not interviewed at hospital B). Consequently, the sample may not have been representative of all the staff groups in the ED at both the meso and micro level. However, it is important to note that the information provided by the participants at the various managerial levels was consistent in relation to the perceived risks when using temporary staff, the preferences for the type of temporary staff used and their management.

In study 2, all consultants who were asked to be CROCs were invited to participate in the study, both pre and post-MTC launch. Although the post-launch sample was

smaller, a mix of both ED and ICU consultants was still achieved, providing a suitable sample for the longitudinal research. However, the Clinical Directors for ED and ICU were only interviewed post-launch due to earlier difficulties in gaining access and their availability for interviews. Although obtaining a longitudinal account from the Clinical Directors would have been preferable, the interviews conducted were able to provide evidence about the managerial decision processes for the launch of the MTC and how the relationship with the consultants changed throughout the negotiating period from the management perspective.

A small cross-site comparison was conducted with hospitals C and D who launched their MTCs at the same time as hospital A. Those involved with the trauma management at these hospitals were interviewed post-launch to highlight any managerial differences between them. A fuller cross-site comparison, including gaining the perspectives of the consultants involved would have highlighted whether the management of any changes in contracts affected the psychological contracts and employment relationships of those involved, but this was beyond the scope of the PhD.

8.3.3 Practical Limitations

Access

As noted in Chapter 4 the study sites were chosen as a result of the ESRC CASE award which had negotiated access with one of the hospitals studied, and comparison hospitals were chosen through negotiations with HR managers (study 1) and because they provided a relevant comparison to the negotiated hospital (study 2). Although having pre-negotiated access to the ESRC CASE hospital was initially useful,

executive level management changed throughout the duration of the research with a resultant loss of support for the study. Also, as the topic of temporary employment became sensitive due to its costs during an economic crisis, gaining access to participants became increasingly difficult. Access to participants in study 1 was initially gained through negotiations with HR Managers who agreed to help to gain access to other managerial levels. Access to staff at the meso and micro level was more difficult, and as a result of the limited help from HR, access was gained through arranging a meeting with the head of the ED's. Permanent staff were recruited by attending staff handovers. For study 2, access was easier as many of the consultants were eager to voice their opinion regarding the introduction of the CROC. Although only a subset of consultants were interviewed both pre and post launch, there was a level of consistency in the responses and themes that emerged in the data.

Departmental Pressures

The ED was a very busy department, often understaffed while striving to maintain patient safety and service quality. This often meant that staff had few opportunities for breaks. On some occasions in study 1 the interviews were speedily conducted in the department, meaning that the researcher may not have had the opportunity to probe as in-depth as would have been desired. To overcome this, an interview schedule with 'core questions' to be asked to each respondent was developed, and the interviewer had to make on-the-spot decisions as to what to probe further. Additionally, as a result of demands on the participant's time, efforts were made to succinctly explain the focus of their research and why their participation was important (Harris, Kelly and Hunt et al., 2008). Interviews were conducted after shift changes and staff handovers on agreement with the clinical managers when the

ED was perceived to be relatively less busy, but this often meant interviewing exhausted staff.

Practicalities of PhD Research

As briefly mentioned in Chapter 6 reporting the results of study 2, follow-up interviews once the work plans and contracts had been agreed had been requested by some consultants. On the 5th February 2012, the CROC became part of the consultants work plan and the voluntary locum period ended. As a result of the lengthy negotiation period, although a number of consultants had voiced a willingness to undertake a third stage of interviews when the contracts had been agreed to report the affects of the contract being finalised and the consequent implications for the psychological contract of the CROCs and patient safety and service quality, there were PhD time constraints meaning a third stage of interviewing could not be conducted.

Throughout the course of this PhD, I faced many delays, barriers and blockages in gaining access to participants (especially in study 1). This in itself was an interesting observation as the topic of temporary employment and its implications for patient safety and service quality had been signalled as a high priority issue, but when conducting the research it was seen as a low priority given the competing primary task of maintaining patient care in a busy ED and hospitals.

8.4 Ideas for Future Research

This thesis has extended research on the psychological contracts of temporary staff in healthcare by focussing on the previously neglected management perspective, highlighting the distinctive characteristics of temporary staffing in healthcare and

developing a model of best practice. However, in doing so, a number of directions for future research have been uncovered to extend and provide further focussed research on the management of the psychological contracts of temporary staff in healthcare. In addition, some of the following suggestions for future research have resulted from areas that could not be covered within this present research.

8.4.1 Temporary Staff Perspectives

The research aims of this thesis concerned why temporary staff are used in healthcare, and how the psychological contracts of temporary staff could be best managed to minimise perceived risks to patient safety and service quality when temporary staff are used. As the management perspective had been previously neglected, this became a particular focus of the research. Consequently, the main recommendation for future research directly related to the present study would be to extend the examination of the management of psychological contracts of temporary staff by including the perspectives of temporary staff. Although the focus of the current research was the management of the psychological contracts from the management perspective, the psychological contract has been defined as '*the perceptions of both parties to the employment relationship*' (Guest and Conway, 2002), and consequently the temporary employees perspective should be reported. Previous research on temporary staff in healthcare has rarely focussed upon the psychological contracts of temporary staff and their perceptions of the 'deal' or the exchange relationships between management and those they work alongside, so this could provide a valuable avenue for future research. This is of particular importance in healthcare, to identify differences between the various types of temporary staff regarding the exchanges they have with management, what they are offered and

consequently what they offer in return. In addition, the inclusion of temporary staff would help to understand why some temporary staff prefer using agencies rather than joining the staff bank, and could also determine the motives for undertaking temporary employment, and how this could affect performance.

Although in study 2 we had the opportunity to interview the CROCs who were in essence temporarily temporary, one of the weaknesses of this study was the lack of access to a wider range of temporary staff. Therefore, there was only a limited view of the psychological contracts of temporary staff and it was gained within the highly complex context of ED departments. One issue that requires further research and clarification in this context and in healthcare more generally is who temporary staff have a psychological contract with. Is it those at the meso level who put in the request to hire temporary staff and manage the staff in the department or the permanent staff who work alongside them, answer any queries they may have, and supervise their work quality? Do temporary staff have multiple psychological contracts? This could influence the content of the psychological contract of temporary staff and what they expect of certain management levels, and how they perform when hired. Additionally, research could seek to identify whether ad-hoc temporary staff actually have the opportunity to develop psychological contracts and if so, who is most likely to breach it and why. A greater awareness of who temporary staff believe they have contracts with could improve how the employment relationship with temporary staff is managed.

8.4.2 Permanent Staff Perspectives

As both case studies reveal, the implications of the use of temporary staff for permanent staff, and how this affects their psychological contracts provides a further issue for future research. This is especially the case with respect to the perceived distributive injustice that can result from the demands made by temporary staff (by not undertaking their role effectively and by delaying departmental throughput leading to increased supervision from permanent staff), or from management (who expect permanent staff to undertake additional duties without providing additional resources or compensation). A better understanding of this could lead to an improvement in the management of temporary staff, including paying more attention to hiring preferred temporary staff and thereby improving morale and behaviour of both temporary and permanent staff and through this ensuring better patient safety and service quality.

8.4.3 Quantitative Measures

The present study purposefully adopted a qualitative approach to allow for an in-depth study about temporary employment in healthcare from a number of stakeholder perspectives (Pope and Mays, 1995), with the case study and semi-structured interviews used to study what was occurring in a real-life environment and the complex phenomena of the ED. The qualitative design did however mean that only a small number of staff were sampled, and the researcher was limited to the staff they had access to. Future research could use a quantitative measure of the psychological contract to determine whether there are differences between the psychological contracts of temporary and permanent staff, as well as between the different forms of temporary staff found in healthcare. Quantitative measures could

be used to test the relationship between the psychological contract and the behaviour, attitudes and commitment of temporary staff and if this affects patient safety and service quality, or whether other systems factors are of more importance. Additionally, quantitative measures can also be used to test the management of the psychological contracts (whether expectations are fulfilled) between different types of temporary staff, and in comparison with permanent staff, to see the significance of the management psychological contract in terms of behaviour, commitment and attitudinal variables and patient safety and service quality.

8.4.4 Comparing Management Practices in Different Healthcare Settings

As discussed in Chapter 4, the London EDs was chosen as the focus of this study due to their particular challenges in staffing, with a national shortfall of ED staff yet simultaneously, EDs having to find a full complement of staff to reach patient safety and service quality targets. Additionally, the ED requires a rapid response and positive team communication so patients are effectively treated, thus how temporary staff are managed in the department is of great importance. However, the use of temporary staff is not limited to the ED, and other departments also need to ensure they have a safe number of staff for patient safety. Future research could compare the management of temporary staff in the ED and in another department where the pressure on staff to provide fast patient care is reduced and continuity of care (a factor that had been considered as a risk to patient safety and service quality in the literature, but not in this research) is of greater importance, e.g. departments caring for long-stay patients. This could determine whether the risks to patient safety and service quality identified in this research are distinctive ED phenomena, or whether such risks are also perceived in other departments. Similarly, questions remain about

whether the preferences for specific forms temporary staff are the same in other departments, and if the policies and protocols implemented are more successful when hiring temporary staff in comparison to the ED.

Hurst and Smith (2011) had reported that London hospitals used notably more temporary staff, explained by an increasingly casual and mobile workforce creating higher vacancy levels. The hospitals of focus in study 1 were both busy London hospitals, thus future research could undertake a comparative study of hospitals in more rural areas where staffing may be more stable, and the need for temporary staff not as critical. Would the management policies and practices be different, and how well are they implemented? Are the risks to patient safety and service quality the same? Do managers in rural hospitals have different psychological contracts with temporary staff in more inner city hospitals, where staffing needs differ? It would then be important to determine whether any differences in the management of the psychological contracts between inner city and rural hospitals have implications for patient safety and service quality.

8.5 Final Conclusions

Due to the nature of the ED, a busy 24-hour department with fast patient throughput, and the national difficulties in recruiting and retaining staff to EDs, the need for temporary staff to cover shifts will continue (on-top of staff absence as a result of illness, training, holiday and maternity). However, senior managers in the NHS will have to continue balancing cost pressures and the concern for patient safety and service quality, and be aware of how changes in organizational policies are disruptive to patient safety and service quality. As cost pressures in the NHS

increase, managers at all levels need to maintain a focus on patient safety and service quality and retain the commitment, motivation and their part of the 'deal' of the psychological contract for all healthcare staff, so they either become or remain permanent in the organization.

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Appendix

- Information sheet and Consent form for Study 1
- Information sheet and Consent form for Study 1
- Interview schedule for Executive Director in hospital A (Study 1)
- Interview schedule for Executive Director in hospital B (Study 1)
- Interview schedule for CEO NHSP in hospital A (Study 1)
- Interview schedule for NHSP site manager in hospital A (Study 1)
- Interview schedule for the bank manager in hospital B (Study 1)
- Interview schedule for clinical managers (Study 1)
- Interview schedule for permanent staff (Study 1)
- Interview schedule for pre-launch CROCs (Study 2)
- Interview schedule for post-launch CROCs (Study 2)
- Interview schedule for clinical managers (Study 2)
- Interview schedule for hospitals C & D (Study 2)

INFORMATION SHEET FOR PARTICIPANTS

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET



Evaluating the Impact of the Employment of Temporary Staff on the Management of Risk in a Hospital, and the Implications for Patient Safety and Service Quality.

We would like to invite you to participate in this PhD research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of this study?

The current study is being undertaken to identify perceptions of different stakeholder groups within the Emergency Department about the advantages and disadvantages of employing temporary staff with respect to risk, and their implications for patient safety and service quality. The study aims to interview those who manage temporary staff to develop an understanding of the process regarding the hiring, monitoring and managing of temporary staff.

Why have I been chosen to participate?

We have invited those in the Emergency Department who are the main users of temporary staff and involved in the management of temporary staff.

What will happen if I take part?

If you choose to take part, you will be asked to complete a short interview. This should take around 30-40 minutes, and may be recorded subject to your permission. Recordings of interviews will be deleted upon transcription. Questions asked relate to your perceptions of temporary employment, why temporary staff are used in the department, perceptions regarding the quality of care that temporary staff provide

and the implications of the use of temporary staff in relation to the management of risk to patient safety and service quality. The interviews will take place in the PSSQ interview room at the hospital, providing a quiet atmosphere for the interviews to take place.

You should only participate if you want to; choosing not to take part will not disadvantage you in any way, and you are free to withdraw from the study at any time, without giving a reason.

What are the benefits of taking part?

The aim of the project is to understand more about the impact of temporary staff in the Emergency Department and their potential risks to patient safety and service quality. By participating you will be contributing to the evaluation of their use and to the provision of information that can help ensure effective working and a high quality of care. Information received through interviews will be used to suggest recommendations for the improved use of temporary staff in the Emergency Department.

What are the risks of taking part?

Helping us with the study will take up little of your time, but we will do our best to minimise any inconvenience to you. Whether or not you decide to complete the interview, your working life will not be adversely affected. You will be free to terminate participation at any time. You can contact that principal investigator to discuss any concerns you may have.

What are the arrangements for ensuring anonymity and confidentiality?

All information collected about you during the course of the study will be strictly confidential and your completed interview data will not be shown to staff at Hospitals A and B. All information will be stored securely, and will only be accessed by members of the PSSQ research team. You will not be referred to by name in the reporting of results. If you disclose information that the researcher feels has implications for professional practice, the researcher may report their concerns to the head of service or other managers. However, the information will be anonymised so that neither you nor anyone else involved could be personally

identified. Information for the study will be stored anonymously for 3 years. Participants have the right to withdraw their data anytime before publication.

Contact for further information:

The postgraduate researcher of this study is Zofia Bajorek, a PhD student in the Patient Safety and Service Quality (PSSQ) Research Centre, based in the Department of Management at KCL. The project is being supervised by Professor David Guest, Director of the Workforce Programme at the PSSQ. Should you have any concerns resulting from your participation in the study, please contact me via e-mail:

zofia.bajorek@kcl.ac.uk

If this study has harmed you in any way you can contact King's College London using the details below for further advice and information:

Principal Investigator:

Professor David Guest

david.guest@kcl.ac.uk

0207 848 3723

Postgraduate Researcher:

Ms Zofia Bajorek

zofia.bajorek@kcl.ac.uk

0207 848 7161

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Evaluating the Impact of the Employment of Temporary Staff on the Management of Risk in a Hospital, and the Implications for Patient Safety and Service Quality.

King's College Research Ethics Committee Ref: _____

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

- I understand that if I decide at any time during the research that I no longer wish to participate in this project, I can notify the researchers involved and withdraw from it immediately without giving any reason. Furthermore, I understand that I will be able to withdraw my data up to the point of publication.
- I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be handled in accordance with the terms of the Data Protection Act 1998.

Participant's Statement:

I _____

agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the study. I have read both the notes written above and the Information Sheet about the project, and understand what the research study involves.

Signed

Date

Investigator's Statement:

I _____

Confirm that I have carefully explained the nature, demands and any foreseeable risks (where applicable) of the proposed research to the participant

Signed

Date

INFORMATION SHEET FOR PARTICIPANTS

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET



Evaluating the Impact of the Consultant Resident On-Call for Trauma and its implications for Patient Safety and Service Quality

We would like to conduct a series of interviews with the consultants and managers involved in the Consultant Resident On-Call (CROC), and repeat this process with the same individuals after the change has been implemented and beyond. Repeating the process over time helps to build a picture of how the change has impacted the consultants and looks at the management processes, the organization and patient safety and service quality.

1. Who has given ethical approval for the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your safety, rights, wellbeing and dignity. This evaluation has been considered by an NHS Research Ethics Committee who classed the work as service evaluation and it has therefore, been granted exemption from full review.

2. Why have I been invited to take part?

We have invited the consultants in Emergency Medicine and the Intensive Trauma Unit who will be affected by the changes of the Consultant Resident On-Call project. We have also invited some managers associated with the process.

3. What does taking part involve?

Taking part will involve completing a short interview. This should take around 30-40 minutes, and may be recorded subject to your permission. Recordings of interviews will be deleted upon transcription. Questions asked relate to your views on the Consultant Resident On-Call project, and any feedback that you may have on this. Please read this information sheet, and if you are happy to participate read and sign the attached consent form.

Please feel free to ask if there is anything that is not clear or if you would like more information.

4. Do I have to take part?

You should only participate if you want to; choosing not to take part will not disadvantage you in any way.

5. What if I change my mind?

You are free to withdraw from the study at any time, without giving a reason.

6. Will my taking part in the study be kept confidential?

Yes. All information collected about you during the course of the study will be strictly confidential and your completed interview data will not be shown to any staff. All information will be stored securely, and will only be accessed by members of the PSSQ research team. You will not be referred to by name in the reporting of results. If you disclose information that the researcher feels has implications for professional practice, the researcher may report their concerns to the head of service or other managers. However, the information passed on would be anonymised so that neither you nor anyone else involved could be personally identified.

7. What are the risks of taking part?

Helping us with the study will take up a little of your time, but we will do our best to minimise any inconvenience to you. Whether or not you decide to complete the interview, your working life will not be adversely affected. You will be free to terminate participation at any time. You can contact the principal investigator to discuss any concerns that you might have.

8. What are the benefits of taking part?

The aim of the project is to understand more about the impact of the change to working patterns and potential change in patient safety and service quality brought about by the introduction of the Consultant Resident On-Call project. By participating you will be contributing to the evaluation process and to provision of information that can help ensure effective working and a high quality of care.

9. What will happen to the results of the study?

The results of the study will be used in a PhD project based in the PSSQ research centre. We are also happy to provide oral or written feedback to

services if requested. In addition, an anonymised summary report of the findings will be posted on our website in due course for those who wish to see them (www.kingspssq.org.uk), and the results may also be published in academic journals or presented at conferences. Your name will not be used at any time.

If this study has harmed you in any way you can contact King's College London using the details below for further advice and information:

Principal Investigator:

Professor David Guest

david.guest@kcl.ac.uk

0207 848 3723

Postgraduate Researcher:

Ms Zofia Bajorek

zofia.bajorek@kcl.ac.uk

0207 848 7161

CONSENT FORM FOR PARTICIPANTS IN RESEARCH STUDIES

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.



Evaluating the Impact of the Consultant Resident On-Call for Trauma and its implications for Patient Safety and Service Quality

Name of Researcher: Zofia Bajorek

- I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected. Furthermore, I understand that I will be able to withdraw my data.
- I understand that relevant sections of the data collected during the study may be looked at by specified individuals from King's College London. I give permission for these individuals to have access to this data.

I agree to take part in the above study.

Name of participant

Date

Signature

Name of person taking consent

Date

Signature

**Evaluating the Management of Temporary Staff in Health Care: Implications
for Patient Safety and Service Quality.**

Interview schedule for the Executive Director in hospital A

This project aims to increase our knowledge and understanding of the relationship between the use of temporary staff and the management, and how any risks to patient safety and service quality could be best managed, with the aim recommend steps to best managed and minimise any risks associated with temporary staff use.

- Could you outline what the general policy is about the employment of temporary staff including a view as to whether it is in principle desirable to have a number of temporary staff for one reason or another?
- Has the level of temporary staff changed over the years in relation to what is occurring in other areas of the hospital?
- How does the use of temporary staff enable you to control for labour costs?
Does this system work?
- Are there any distinctive issues with the recruitment of temporary staff in the ED?
- Is there a preferred hierarchy of use of temporary staff at the hospital, and could you describe this?
- What is the role of NHSP at the hospital, and is it as effective as it could be?
- Are there any ways that you think the role of NHSP could be improved?
- Do you think that NHSP has more advantages in comparison to an internal staff bank?
- Why are agency staff still used in the ED, even though they can be more expensive than permanent staff?
- Do you have a sense of what proportion of the staff that you have doing extra work on a temporary basis are NHSP as opposed to agency?
- Is there any evidence of the number of patient complaints increasing in relation to the use of temporary staff in the ED?

- How are risks/incidents involving temporary staff monitored and how are they dealt with?
- What do you think are the main risks in relation to the use of temporary staff and patient safety and service quality?
- Is there more of a risk in the ED, or have similar issues been identified in other areas of the hospital?
- Why are there problems in hiring the sufficient number of temporary staff in the ED?
- Why do you think that individuals undertake temporary employment?
- How does the hospital monitor the number of hours that temporary employees undertake?
- Are there any incentives to try and hire the temporary staff you like to the permanent vacancies, or incentives to encourage permanent staff to join the staff bank?
- What are the hospitals policies in terms of the induction, training and professional development of temporary staff? How do you ensure that temporary staff receive the necessary induction and help they need to perform their roles?
- Have there been any differences in the number of temporary staff seen since the introduction of other government initiatives, for example, the European Working Time Directive?
- Do you have any further questions or comments about the use and management of temporary employees in the hospital and the management of risks to patient safety and service quality?

**Evaluating the Management of Temporary Staff in Health Care: Implications
for Patient Safety and Service Quality.**

Interview schedule for the Executive Director in hospital A

This project aims to increase our knowledge and understanding of the relationship between the use of temporary staff and the management, and how any risks to patient safety and service quality could be best managed, with the aim recommend steps to best managed and minimise any risks associated with temporary staff use.

- Could you outline what the general policy is about the employment of temporary staff including a view as to whether it is in principle desirable to have a number of temporary staff for one reason or another?
- Has the level of temporary staff changed over the years in relation to what is occurring in other areas of the hospital?
- How does the use of temporary staff enable you to control for labour costs?
Does this system work?
- Are there any distinctive issues with the recruitment of temporary staff in the ED?
- Is there a preferred hierarchy of use of temporary staff at the hospital, and could you describe this?
- What is the role of the internal staff bank at the hospital, and is it as effective as it could be?
- Are there any ways that you think the internal staff bank could be improved?
- Do you think that the internal staff bank has more advantages in comparison to external agencies such as NHSP?
- Why are agency staff still used in the ED, even though they can be more expensive than permanent staff?
- Do you have a sense of what proportion of the staff that you have doing extra work on a temporary basis are NHSP as opposed to agency?
- Is there any evidence of the number of patient complaints increasing in relation to the use of temporary staff in the ED?

- How are risks/incidents involving temporary staff monitored and how are they dealt with?
- What do you think are the main risks in relation to the use of temporary staff and patient safety and service quality?
- Is there more of a risk in the ED, or have similar issues been identified in other areas of the hospital?
- Why are there problems in hiring the sufficient number of temporary staff in the ED?
- Why do you think that individuals undertake temporary employment?
- How does the hospital monitor the number of hours that temporary employees undertake?
- Are there any incentives to try and hire the temporary staff you like to the permanent vacancies, or incentives to encourage permanent staff to join the staff bank?
- What are the hospitals policies in terms of the induction, training and professional development of temporary staff? How do you ensure that temporary staff receive the necessary induction and help they need to perform their roles?
- Have there been any differences in the number of temporary staff seen since the introduction of other government initiatives, for example, the European Working Time Directive?
- Do you have any further questions or comments about the use and management of temporary employees in the hospital and the management of risks to patient safety and service quality?

Evaluating the Management of Temporary Staff in Health Care: Implications for Patient Safety and Service Quality.

Interview schedule for NHSP CEO Hospital A

This project aims to increase our knowledge and understanding of the relationship between the use of temporary staff and management, and how any risks to patient safety and service quality could be best managed, with the aim recommend steps to best managed and minimise any risks associated with temporary staff use.

- Can you provide an initial outline to the service that NHSP provides to the hospital?
- What level of staff are employed? How long for and what kind of roles do they undertake?
- What is the process of hiring staff through NHSP?
- Can specific wards ask for specific individuals? And alternatively can individuals ask for specific wards?
- What happens if NHSP cannot find an appropriate individual?
- If agencies have to be contacted, is there a hierarchy of agencies that are used?
- Is there a time limit for how long individuals can work for NHSP?
- How do NHSP monitor the hours of temporary employees?
- Are there areas that are more popular to work in than others? Similarly, are certain times of the day that are more popular than others?
- What sort of complaints do you receive from wards about NHSP employees?
How are these complaints dealt with?
- How many complaints do you receive?
- How often are people asked to leave the staff bank?
- How successful do you think the NHSP system is? Are there any ways in which you think it could be improved?
- Do you think that temporary staff pose a risk to patient safety and service quality and in what way? Are they any worse than permanent staff?

- How do you think temporary staff could be best managed?
- What do NHSP provide in terms of training of temporary staff?
- What guidelines/policies do you provide to temporary staff as they start in the hospital?
- Do you get any complaints for temporary workers about their experiences of working on the wards?
- How does the management of NHSP at this hospital compare to others?

Evaluating the Management of Temporary Staff in Health Care: Implications for Patient Safety and Service Quality.

Interview schedule for NHSP Site Manager Hospital A

This project aims to increase our knowledge and understanding of the relationship between the use of temporary staff and management, and how any risks to patient safety and service quality could be best managed, with the aim recommend steps to best managed and minimise any risks associated with temporary staff use.

- Can you provide an initial outline to the service that NHSP provides to the hospital?
- What is your relationship with the hospital? Who is the main point of engagement?
- What level of staff are employed? How long for and what kind of roles do they undertake?
- What is the process of hiring staff through NHSP?
- Can specific wards ask for specific individuals? And alternatively can individuals ask for specific wards?
- What happens if NHSP cannot find an appropriate individual?
- Are some departments harder to fill than others?
- If agencies have to be contacted, is there a hierarchy of agencies that are used?
- Is there a time limit for how long individuals can work for NHSP?
- How do NHSP monitor the hours of temporary employees?
- Are there areas that are more popular to work in than others? Similarly, are certain times of the day that are more popular than others?
- What sort of complaints do you receive from wards about NHSP employees? How are these complaints dealt with?
- How many complaints do you receive?
- How often are people asked to leave the staff bank?

- How successful do you think the NHSP system is? Are there any ways in which you think it could be improved?
- Do you think that temporary staff pose a risk to patient safety and service quality and in what way? Are they any worse than permanent staff?
- How does NHSP cope with the perception that temporary staff are not as safe for patient safety and service quality in comparison to permanent staff?
- How do you think temporary staff could be best managed?
- What do NHSP provide in terms of training of temporary staff?
- What guidelines/policies do you provide to temporary staff as they start in the hospital?
- Do you get any complaints for temporary workers about their experiences of working on the wards?
- How does the management of NHSP at this hospital compare to others?

Evaluating the Management of Temporary Staff in Health Care: Implications for Patient Safety and Service Quality.

Internal Bank Manager at Hospital B

This project aims to increase our knowledge and understanding of the employment relationship between management and temporary staff and the management of risks to patient safety and service quality, and aims to recommend steps to minimise that risk. The project also aims to identify the perceptions of different stakeholder groups within general and clinical management about the advantages and disadvantages of employing temporary staff with respect to risk.

- Could you outline what the general policy is about the employment of temporary staff including a view as to whether it is in principle desirable to have a number of temporary staff for one reason or another? What % of temporary staff do you aim for?
- Can you then outline the policies for the Emergency Department? How if at all do they differ from the general policy?
- What is the proportion of Bank and Agency staff currently working in ED? How does this divide out between doctors and other staff? To what extent (and for what reasons) is this above or below the level of temporary use you aim for?
- How are the hierarchy of agencies chosen?
- What has the impact of the recent agency legislation been for the use of temporary staff?
- Have there been many policies or initiatives to encourage staff to join the staff bank? What were they? Were they successful?
- Who should initiate the call for using temporary staff? Who does it in practice?
- Is there a hierarchy of preference over which temporary staff you would want to use? (this is a bit vague)
- Are there differences in the recruitment of temporary cover for nurses and doctors/consultants? (sort of covered above?)
- Have you seen any noticeable changes in the type of, or use of temporary staff in the hospital? Emergency Department?
- Is there any evidence that certain types of temporary staff pose a greater or lesser risk to Patient Safety and Service Quality?

- Have temporary staff ever had to be removed because of patient safety and service quality concerns?
- How do you monitor the performance of temporary staff especially around patient safety and service quality issues, broadly defined (e.g. attendance, punctuality etc)
- Is there any official evaluation of the quality patient safety and service quality provided by temporary staff?
- What temporary staff checks do you undertake when considering suitability of bank/agency staff? Are there any specific to the ED?
- Do you have any trust policies for induction? Do you provide an induction check list that temporary staff should receive, or if this the role of the ward they are placed in?
- How are patient safety incidents involving temporary staff monitored and dealt with?
- What feedback to temporary staff receive from any placements they are put on?
- How are the hours that temporary staff work monitored?
- Do you have any further comments you would like to make?

Evaluating the Management of Temporary Staff in Health Care: Implications for Patient Safety and Service Quality.

Interview schedule for Clinical Managers in hospitals A and B

This project aims to increase our knowledge and understanding of the relationship between the use of temporary staff and the management, and how any risks to patient safety and service quality could be best managed, with the aim recommend steps to best managed and minimise any risks associated with temporary staff use.

The aim of this stage is to interview those who hire and manage temporary staff.

Background to ED

- Could you describe to me why you hire temporary staff?
- Who leads to the decision to use temporary staff?
- Could you describe to me the process you go through when organising temporary cover?
- What are the typical numbers of temporary staff needed in the department, in proportion to permanent staff?
- Have you a preference over what type of temporary staff you would use in the department? (bank/agency/multi-post holder) What type do you usually end up getting?
- Does the current system provide suitable temporary employees? If not, why?

Temporary staff integration

- When a temporary member of staff arrives to cover a shift, what level of induction do they receive?
- What relevant training/experience checks do you undertake?
- How do the roles of temporary and permanent staff differ?
- How well are the temporary staff integrated into ward teams?
- How would you describe the permanent and temporary staff relationship?

Evaluation of temporary staff

- How would you describe the quality of care the temporary staff provide?
- Do you, and in what way do you perceive the attitude and commitment of temporary employees to differ in comparison to permanent staff members?
- Are the differences in quality provided between bank and agency staff, or multi- post/bank/agency only staff?

Impact on patient safety and service quality and risk management

- How does/can the presence of temporary staff impact patient safety and service quality?
- Do you think a temporary member of staff poses a greater risk to patient safety and service quality? And why (not)?
- Could you describe to me any ways in which you think that temporary staff can improve patient safety?
- Can you provide any examples where things have gone well and when things have gone badly when using temporary staff? How can such risks be avoided?
- How do you attempt to manage/minimise the risks related to the use of temporary staff?
- How are patient safety incidents involving temporary staff dealt with?

Concluding questions

- Have there been any other factors that have affected the requirements for the use of temporary staff?
- Have you anything else to add that has not been covered?

Evaluating the Management of Temporary Staff in Health Care: Implications for Patient Safety and Service Quality.

Interview schedule for Permanent staff in hospitals A and B

This project aims to increase our knowledge and understanding of the relationship between the use of temporary staff and the management, and how any risks to patient safety and service quality could be best managed, with the aim recommend steps to best managed and minimise any risks associated with temporary staff use.

The aim of this stage is to interview those who work alongside temporary staff.

Background

- How often do you work alongside temporary staff?
- On a typical shift, what proportion of staff are temporary staff?
- Why do you think the hospital hires temporary staff?
- Do you have a preference about the type of temporary staff hired (bank/agency/multi-post holder). Why (not)?
- What type of roles/activities/duties do the temporary staff typically cover?
- Can you comment on the similarities/differences between the different types of temporary staff who work in the division? Are there any implications for patient safety and service quality?
- To what extent do you believe the division employs suitable temporary cover? Do you think the cover can be improved in any way?

Evaluation of Temporary Staff

- How would you describe the quality of patient safety that the temporary staff provide?
- To what extent and in what way do you think the attitudes and commitment of temporary employees differ to yours as a permanent member of staff?

- To what extent and in what way do you perceive the behaviour and performance of temporary employees to differ in comparison to permanent staff members?
- To what extent and in what way are there differences in the quality of care provided by bank/agency and multi-post holding staff?

Impact on patient safety and service quality and risk management

- How does/can the presence of temporary staff affect patient safety and service quality?
- To what extent do you think temporary staff pose a greater risk to patient safety and service quality?
- Can you provide any examples where things have gone well when using temporary staff?
- Can you provide examples where patient care has been negatively affected when using temporary staff?
- How can such risks be avoided?
- How do you attempt to manage the risks related to the use of temporary staff?
- How are patient safety incidents involving temporary staff dealt with?

Temporary staff Integration

- How important do you consider a local induction to be for temporary staff, and does every member of staff receive one?
- When a temporary member of staff enters the division, have you ever been asked to conduct a local induction? Who is responsible for ensuring this happens?
- What information is included in an induction?
- What information do you think is necessary for the temporary members of staff to know so that they can conduct their roles effectively?
- How would you describe the relationship between temporary and permanent staff?
- What do you do/have you done to help temporary staff?
- How and in what way do the roles of temporary staff and your role differ?

- In what way do you perceive that your role changes, or do you have to take on extra tasks when there are temporary staff?
- If you do have to take on extra roles, is there any recognition of this, and in what way does this affect your behaviour, attitude or commitment towards the hospital or your role, and the temporary staff?

Concluding questions

- What other factors do you think affect the performance of temporary staff in health care settings?
- Have you ever undertaken any temporary shifts in the hospital?
- If you have, do you perceive that you behave differently when working as a temporary member of staff?
- Is there anything that you would like to add about the use of temporary staff and the affect on your role, or the use of temporary staff in general that has not already been covered in this interview?

Evaluating the Impact of the Consultant Resident On-Call for Trauma and its Implications for Patient Safety and Service Quality

First stage interview schedule

This interview aims to determine the consultant's current role, the perceived impact of the CROC on this role, and the perceptions of the introduction on the Major Trauma Centre for the organization, the individual and for patient safety and service quality. Questions will also be asked about the management of the launch.

- Can you describe to me where you are currently based, how long you have spent in that role, and how long it has been since you were involved in shift and overnight work?
- What do you enjoy most/least in your current role?
- Can you explain to me how the Consultant Resident On-Call scheme will change:
 - your main role
 - your current working patterns?
- Do you believe it is sensible for Hospital A to introduce the major trauma centre?
- Do you agree with the aims of the CROC? Why (not)?
- What positive impacts on the CROC do you envisage?
 - Organizational
 - Personal
 - Professional
 - Patient-Safety
 - Service Quality
- What negative impacts do you envisage?

- How do you think this will affect your work-life balance? What advantages and disadvantages do you foresee?
- How do you think the changes will impact other members of the trauma team? What impact will it have on team development/knowledge transfer?
- What do you think the long-term implications will be?
 - Organizational
 - Personal
 - Patient-Safety
- What are the contingency plans/procedures in place to cover for illness/vacancies/annual leave?
- How do you feel the change process is being managed?
- How far and in what way have you been involved in the consultation process?
- How fully do you feel you have been kept informed about the development of CROC?
- Have you got any other points to raise that I have not already covered?

Evaluating the Impact of the Consultant Resident On-Call for Trauma and its Implications for Patient Safety and Service Quality

Second stage interview schedule

This is a follow up interview after the pre-implementation interviews, picking up on themes identified then. The follow up interview will discuss how the launch of the Major Trauma Centre has impacted upon the consultant working hours, the organization, work-life balance and patient safety and service quality. The interviews also aim to capture views on the management of the process, and any critical incidents of the success or failure of the Centre.

- Can you describe to me how your role has changed as a result of the introduction of the major trauma centre?
- How has your involvement in the Centre affected your other work?
- Are the changes in your role as a result of working for the Major Trauma Centre better or worse than you had expected, and why?
- What has been the level of trauma cases that the MTC received, when you have been on duty? Is this more or less than you expected?
- What extra resources have had to be put in place to help with the launch and running of the MTC?
- To what extent do you feel you have been kept informed by management of changes/developments in the Centre. What more could be done to keep you up-to-date?

Experience of being on-call

- How many times have you been the consultant resident on call?
- How did you find it?
- What did you do when on call but not dealing with trauma cases?

- Did you feel as if there was a need for you to undertake other roles on the ED when you were not dealing with trauma cases?
- How satisfactory is the accommodation provided to the CROC?
- What positive impacts of the Major Trauma Centre and being CROC have you experienced? An can you give specific examples?
 - Patient Safety/Service Quality
 - Organizational
 - Personal
 - Professional
- What negative impacts have you experienced?
- How has the introduction of the MTC and the CROC affected your quality of working life and work –life balance?

Teams and communication

- I understand a team has to be gathered quickly when a trauma patient arrives, and you lead team. How effectively is this working?
- How effective is the communication in the trauma team?
- As far as you are aware what impact has the major trauma centre had on knowledge/information transfer?
- As far as you are aware, has there been any noticeable differences in the way that ED and ICU staff are covering the trauma? If yes, what have they been, and why do you think that has occurred?
- Has collaboration between ED and ICU changed as a result of the MTC, and how?
- How and in what way have communication links with other areas of the hospital changed as a result of the centre?
- Have you noticed any impact on other areas of the hospital or ward teams?
- Has there been a problem with staff absence as a result of working in the MTC?

Long-term and change process

- On the basis of your experience so far, do you think there is a need for a consultant resident on-call?

- How sustainable do you think the MTC and CROC is in its present form?
- In your view have there been any changes in the quality of care provided in patient outcomes as a result of the Centre? If yes, what is your basis on saying this?
- In what form have you been able to provide feedback/problems/suggestions for practice now having had the opportunity of working as a CROC?
- To what extent do you feel concerns/suggested are being listened to?
- Do you think the experiences so far in the Centre is likely to make those consultants who did not agree to become CROC's any more or less willing to become a CROC if asked now?
- In retrospect, what sort of things should management have done differently in introducing the centre?
- I understand that some of the CROC's are employed on temporary contracts. How did this come about and what impact is it having on the operation of the centre?

Any other questions?

- Have you any other points to raise that have not already been covered?

Evaluating the Impact of the Consultant Resident On-Call for Trauma and its Implications for Patient Safety and Service Quality

Interviews with Clinical Directors

During this interview we wish to discuss the launch of the Major Trauma Centre from the managerial perspective, to gain information regarding why certain decisions were made during the planning and the launch of the MTC, and the managerial perspective on the MTCs affect for patient safety and service quality outcomes.

- What is your role in relation to the management of the Major Trauma Centre?
- Why did the hospital decide to introduce the Major Trauma Centre?
- What was the rationale for the use of both Emergency Medicine and Intensive Care Unit consultants?
- Why have the two departments staffed the hours differently? Is there one option that is proving better for patient safety and service quality?
- Has the relationship between the two departments changed?
- Why were the consultants put on the locum-contract?
- Why was there such a delay in the organization of the contract?
- Is the rota now organised, and had a contract been agreed?
- How were changes to the contract/rota communicated to those involved? What were the channels of communication? Do you think this process could have been improved?
- How frequently will consultants now have to undertake the CROC, and what impact will this have on their existing roles/department?

- What happens to the CROC rota if you do not get enough staff to participate?
- What has the level of Major Trauma been?
- Has the Major Trauma Centre be seen to be beneficial to patient outcomes?
- What has the impact been for staff morale/quality of working life for those involved in the change of rota?
- What are the financial implications of the Major Trauma Centre set up, and locum contract period for the hospital?
- What have been the principal reasons for individuals deciding not to participate in the CROC?
- Are people convinced that the current rotas and plans are suitable?
- What is the relationship like between the ICU and ED consultants? What has been the impact on other staff in both departments?
- Has bringing people in from an external department to work in the ED, who maybe do not understand the working of the department been a risk to patient safety and service quality?
- What training have consultants had, both in major trauma and trauma leadership?
- What do you perceive the advantages of using in-house consultants to manage the major trauma centre, in comparison to what other trauma centres are doing – when they bring in external staff?
- Are you in contact with the other MTC's in London as to how they organising their rota's/staff?
- If you could have managed or implemented the rotas differently when introducing Major Trauma, what would you have done?

Evaluating the Impact of the Consultant Resident On-Call for Trauma and its Implications for Patient Safety and Service Quality

Interview with Hospitals C and D

This interview aims to compare the management of the launch of the MTC at Hospital A to Hospitals C and D who were designated as MTCs and launched their MTCs at the same time as Hospital A. The interviews are to see how the management methods were similar or differed, and how the management of the launch of the MTC in these hospitals had implications for patient safety and service quality, and the employment relationship with the consultants involved.

- What is your role in relation to the management or development of the Major Trauma Centre?
- How is the Major Trauma staffed at this hospital? How do you ensure the 24 hour consultant cover?
- Was there an enthusiasm in general to get involved in trauma?
- Was there a need to negotiate new contracts with those having to provide trauma care?
- What is your level of major trauma? Have there been any notable differences/changes in the incidence of trauma seen?
- Was having 24 hour consultants available for trauma a post Darzi initiative? Was there anything similar before the Healthcare for London report?
- Did the introduction of the MTC entail major changes to the working patterns of those involved? How were these changes managed? Do you think anything else could have been done to ensure better management?

- Is having 24 hour consultant cover actually necessary? What is the level of trauma?
- What impact has the MTC had on patient safety and service quality?
- What have the positive benefits of the MTC been for the organization / consultants / patient safety and service quality?
- Have there been any negative impacts of the MTC?
- Were you in contact with the other London MTC's to discuss how best to staff MTC's?
- What has the impact been for staff morale/quality of working life since the MTC began?
- What training has been provided to help with major trauma, or trauma leadership? Have all those involved taken part in the training?
- How were any changes to rota's/job plans communicated/managed with the staff involved?
- Do you think there are better ways to staff the MTC?
- What are the financial implications of the MTC for the hospital?
- Do you think that the MTC here can be managed in a different or a better way?
- Have you any other comments to add about the management of the MTC launch that have not been covered in this interview?